

of the status of the profession and the degree of recruitment? You have probably been to some of the Dominions and the States?—I have, to both. In the United States there are one or two medical schools which attract the really best men in the whole of North America. I think their quality is quite a lot higher than the average quality of students in this country. But if you took all the schools in the States and averaged them I do not know what the answer would be. I certainly would not like to think it would be higher.

1814. And the status of the profession in the community in the States. Would it rank higher in that community than ours does in this or not?—I really do not know the answer to that. Have you any impression, Sir Russell?—*Sir Russell Brain*: I could not say.

1815. *Professor Jewkes*: You will probably be aware that the earnings of doctors in America in the last ten years have risen very rapidly indeed, so much so that their earnings outstrip the earnings of most other professions I would think, and perhaps even those of the ordinary wage-earner and salary-earner. Is that having any effect in drawing doctors, young doctors, from this country to North America, perhaps not direct to the United States, but through the triangular movement of going to Canada and then going to America? The United States doctor's position relatively has become much better than it was ten or twenty years ago.—*Dr. Platt*: I do not know that we have got figures yet. We are going into figures for emigration, and they did appear to show a very considerable increase in the people going to Canada. But if you do not mind I would rather leave that until a later stage when we have checked up. We do not want to give figures which are not right.—*Sir Russell Brain*: I think from personal experience there is quite a lot of evidence that there is a stream beginning flowing towards the United States where men are offered much better remuneration, and where very often there are more attractive facilities in the way of technical aids, and so on.

1816. And it would take place by this process of going to Canada perhaps first, because a qualified man here is not automatically qualified in the United States, is that correct?—That is true I think,

yes. Some of them actually go over and start again and qualify over there; and then, of course, there are other more academic posts where it does not apply.

1817. *Chairman*: When you say they are offered a better remuneration, Sir Russell, does that mean as salaried members?—I was thinking of salaried members, research workers, and so on, of University hospitals and research Institutes.

1818. *Sir Hugh Watson*: Dr. Platt, following on this question of the quality of entrants into the profession, you touched on one matter which obviously distresses you, and that is you say you find doctors are no longer sending their sons into the profession in the same proportion that they were. You think there is evidence to show that?—*Dr. Platt*: A lot of people seem to think so. I do not know that we have any figures for this, and I think that it probably fits medical students in Oxford and Cambridge more than the other universities. This is not I am afraid based on facts and figures. Can you give any better answer to that, Sir Harold?—*Sir Harold Boldero*: No, Sir, there are no figures available.

1819. You have got this from the Mountford Committee's report. You say so in your note.—Yes.

1820. It is quite true that that is a reasonable inference from the Mountford Committee's report, but they give another figure which you do not quote—namely of all students at universities over 50 per cent. of those whose fathers are or were doctors are themselves in the medical faculties. This would tend to make one feel that it was not quite so bad as you think.—*Dr. Platt*: No.

1821. It would seem a high proportion considering all the professions to which young men have access.—So it always has been a high proportion.

Sir Hugh Watson: Yes, you and I can think of many families where there have been doctors for generations.

1822. *Chairman*: What would be significant would be a very marked change, and a change more marked in your profession than in some of the others.—Yes.

1823. Because there are changes going on all the time.—Yes.

Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

1

First Day, Thursday, 5th December, 1957

WITNESSES

Socialist Medical Association
Whole-Time Consultants' Association



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Witnesses

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

FIRST DAY

Thursday, 5th December, 1957

Present:

SIR HARRY PILKINGTON (*Chairman*)

MRS. K. M. C. BAXTER

MR. A. D. BONHAM-CARTER, T.D.

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

PROFESSOR JOHN JEWKES, C.B.E.

MR. I. D. MCINTOSH, M.A.

SIR DAVID HUGHES PARRY, Q.C.

SIR HUGH WATSON, D.K.S.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

Memorandum submitted by the Socialist Medical Association

In submitting evidence on this subject the Socialist Medical Association wishes to make it clear that it is concerned with principles rather than precise amounts of remuneration but believes that the latter can never satisfactorily be achieved until the former have been accepted. The Royal Commission has been asked to consider a group who are paid by the NHS by a great variety of methods and including some who acquire incomes by a further variety of methods outside the service. The SMA believes that the principle already established in the NHS for all but a small group of health workers, that of *whole-time salaried employment* must be established for all if a satisfactory method of payment is to be worked out. Particularly is this the case in the hospital services where not only would the method be more economical (as shown by Titmuss and Abel-Smith) but more efficient and conducive to a far higher standard of medical care. The arguments are so powerful that it is clearly wrong to perpetuate a method which encourages people to take part-time employment at greater cost to the nation.

PROPOSALS AND RECOMMENDATIONS

A. HOSPITAL DOCTORS' AND DENTISTS' REMUNERATION.

1. *Whole-time Staff.*

- (a) The basic salary of each grade should be related to the cost of living and reviewed annually.
- (b) The system of increments should be retained but should be spread over a longer period so giving better incentives than at present.
- (c) Merit Awards should be abolished.
- (d) Responsibility allowances should be introduced, related to posts and not to individuals.
- (e) There should be two increment ladders covering the higher grades of hospital officer. Up to Registrar the posts should be regarded as preliminary to a decision whether to go on in hospital service or to become a GP. The person

who decides to remain in hospital and who is accepted as suitable, should start in the "specialist" grade. This should be devised so as both to provide (1) a "sticking point" (but at an older age than at present, say 40) for those who do not gain promotion or for posts not carrying fullest responsibility, and (2) for promotion either within the same hospital or elsewhere. Such promotion should be to "Consultant" grade, the increments for which should start later and go on longer than at present. There must be free movement at the lower ranges of the "specialist" ladder so as to allow for changes in specialisation and there should be an overlap of the two ladders. S.H.M.O.s and existing Senior Registrars should be absorbed as "specialists" except those who are now doing consultant work and there should be an increase in consultant posts. The system must retain as much flexibility as possible as medicine is still a growing thing.

- (f) *Retirement.* The present arrangements concerning retirement should be retained but people should be able to retire earlier where they themselves consider it desirable without foregoing all their pension rights.

2. *Pre-Registration Staff—Doctors.*

Recommendations:

- The Pre-Registration House Officer immediately on qualifying to be guaranteed by the Hospital Service one year's salary and one year's full employment. This guarantee by the Hospital Service would make it obligatory, subject to the usual safeguards, on the House Officer to accept any suitable post offered by the Hospital Service.
- The present salary scales for House Officers are totally inadequate and should be raised immediately by at least 50 per cent.
- The need of House Officers for time and energy for further study should be recognised and the maximum hours worked should be reduced. House Officers must not have the feeling of being exploited and the establishment of every hospital must be such that working hours are much less than is often the case today.

3. *Pre-Registration Staff—Dentists.*

In dentistry the problem of recruitment is likely to continue to be difficult and some method must be devised to make early years of dentistry on a whole-time basis more attractive. It is suggested that grants should be made to suitable students to cover the whole cost of training, and where necessary, maintenance subject to their agreeing to spend the first three years after qualification working whole time in the NHS.

4. *Part-time or Sessional Staff.*

Recommendations:

- Care should be taken not to encourage (by advantageous terms etc.) part-time or sessional employment.
- As soon as practicable the Regional Hospital Boards should terminate existing contracts of employment with Consultants and Specialists on a part-time or sessional basis and offer fresh employment on a whole-time salaried basis only.

5. The Pay-Bed system (which, among other disadvantages, enables part-time specialists to obtain "side earnings") should be abolished in the Hospital Service.

Comments on the Foregoing Recommendations.

1. The salaries suggested for consultants in the Spens Report were based on the assumption that there would be a marked diminution in private practice but this has not happened and the Guillebaud Report stated that there should be no financial incentive for any full-time consultant to transfer to a part-time contract in view of the many incentives which exist.

2. At the moment most consultants who sit on influential committees are themselves employed on a sessional basis and continue to advise that method and, it is believed, to make it more difficult to persuade Hospital Boards to create more whole-time consultant posts which would help Senior Registrars to get promotion. It is not unknown

for part-time consultants to exceed their nine sessions, doing as many as 10-15 notional half-days. This increases the difficulties of Senior Registrars by reducing opportunities for promotion.

3. The whole-time staff in Hospitals are experiencing a steady lowering in their standards of living by constantly increasing costs and gradual diminution in the value of money. The basic salary of each grade in the hospital service should be related to the cost of living and ensure that salaries are in accord with present living costs.

4. The recruitment of medical students should be based on as wide a social catchment as possible since doctors must understand their patients' lives and social backgrounds as emphasis is laid on "stresses" as well as on diseases. The student should be given general cultural, as well as technical training, so that he can cope with widely varying problems and become a mature person. Many factors militate against this wide social recruitment, particularly the length of the course, its cost, the late age at which earnings begin and the poor commencing salaries. Grants therefore to medical students should be such that they will assist recruitment.

5. In the House Officer and Registrar grades a higher salary scale would not entirely prevent the present-day anxieties and frustrations. At this stage the young doctor is constantly changing posts and needs more assistance in moving and should not suffer long gaps between jobs. It is important also that trainee doctors should feel there are genuine prospects of promotion within the service.

6. Guaranteeing one year's salary and employment to the pre-registered doctor at least relieves his anxiety regarding periods of unemployment and ensures an opportunity to consider his future either in the Hospital Service or in General Practice. The first year's salary should be adequate and the normal hours of work not more than 50 hours per week which would allow for study and continuation of training.

7. The part-time or sessional Consultant and Specialist has elected to contract out of whole-time service to undertake private practice, to get more opportunities for more "side-earnings" which the Guillebaud report states cannot be assessed or determined for Tax purposes. As a result the part-time consultant or specialist is torn between loyalty to his responsibility and the desire to indulge in "side-earnings". The calculation of "notional" half-days, the payment for travelling time, the possibilities of tax-rebates all give to the part-time privileges denied to the whole-time consultant. In addition much of the advice tendered to the Ministry and Hospital Boards is biased in favour of part-time contracts.

8. The system of part-time or sessional employment should therefore cease as soon as practicable and whole-time employment be established throughout the hospital service.

9. The Pay-Bed system is fostered by the part-time specialists to enable them to get "side-earnings". It is an abuse of the NHS facilities and at its expense. Indeed the NHS is subsidising the part-time consultant without any return. It should be possible to obtain bed-privacy whenever required without the retention of the Pay-Bed system.

B. GENERAL MEDICAL PRACTITIONERS' REMUNERATION

The Socialist Medical Association believes in the principle and policy of organising the whole of the Health Service on a whole-time salaried basis and considers that the time is opportune to introduce whole-time Health Centre General Medical Practitioner Services throughout the country. It proposes to the Royal Commission that it advises the Government to organise the General Medical Practitioner services in, and through Health Centres. The SMA believes that local government should be so reformed that the NHS can be operated by a single democratically elected health authority on a regional basis but until that is done the contract of the General Practitioners would remain with the local Executive Council. The Health Centres envisaged are fundamental to real team-work in general practice but they need not be elaborate and must not be too large. The GP must, of course, have full and open access to the ancillary services he needs.

1. Recommendations

- (a) The basic salary of each General Medical Practitioner should be related to the cost of living.

- (b) The General Medical Practitioner who enters a health centre service would be paid on a salaried basis. Other doctors should be given the option at once of choosing between the capitation fee or salary and the fact that all overhead expenses of doctors in health centres in regard to surgeries, etc., would be free to the doctor would be an excellent incentive to doctors to come into such centres.
- (c) A system of increments to doctors working in health centres, coupled with payments for special skill and responsibility allowances should be instituted to provide maximum incentive.
- (d) The employment of General Medical Practitioner Assistants should be discontinued. They, with other General Medical Practitioners with numbers on their lists below 2,500 will take over the excess patients shed by those with above 2,500.

2. Retirement age for all General Practitioners should be 65 with opportunities for re-employment but not beyond 70 years of age.

3. Retirement should be allowed when the individual himself considers it desirable without surrendering all rights to pensions.

C. GENERAL DENTAL PRACTITIONERS' REMUNERATION

The Socialist Medical Association considers that the time is opportune to introduce full-time Health Centre General Dental Practitioner Services throughout the country and proposes to the Royal Commission that it advises the Government to organise the General Dental Practitioner Services in and through Health Centres.

1. Recommendations

- (a) The General Dental Practitioner who enters the Health Centre service should be offered a salary comparable with the annual earnings of the established Dental Practitioner.
- (b) Annual increments should be granted to whole-time salaried General Dental Practitioners in such a way as to create the maximum incentive.
- (c) Terms of employment and opportunities for advancement should be such as to encourage pre-registration dental house officers to enter Health Centre practice and to remain in it.

2. Retirement for all General Dental Practitioners should be at 65 with discretion of the Executive Council exercised for opportunities of re-employment where desirable.

3. Dentists should have the right to retire before the age of 65 when they themselves consider it desirable without surrendering all pension rights.

Comments on the Foregoing Recommendations.

1. The increased remuneration given to the General Medical Practitioner who continues to work outside the Health Centre should only be given on the understanding that sub-standard surgery and waiting-room accommodation is improved and adequate administrative services provided as recommended in the Danckwerts Award. Since so much of this accommodation is provided in old houses and premises almost beyond repair, it would be uneconomical to re-equip and rebuild and would place too costly a burden on the General Medical Practitioner.

2. The answer is to provide Health Centre facilities with rent-free accommodation for surgery and waiting room suites, administrative and technical personnel services, transport, reduction in hours of service and freedom from the burdens of mortgage and house purchase, of staff difficulties and of maintenance of administrative services. This would provide the opportunity to retain the closest "patient-family doctor" relationship and at the same time to be able to work more closely with his colleagues in the Health Centre.

3. Provision for training of Dental Students is well below that which is required to replace the present losses in the Dental Services; the Government must take immediate steps in conjunction with the teaching hospitals to provide these additional facilities. There are many factors involved but they must be overcome.

4. To include the Dentists in the Health Centres will be a step towards linking up the School Dental Service with the General Dental Practitioner Service and will assist in a more effective approach to orthodontic work and the prevention of dental disease.

5. The reduction of Lists of Patients to 2,500 will enable the full employment of many General Medical Practitioners who have small Lists and a considerable reduction in the burden carried by those who possessed the large Lists, with the safeguarding of their income. It will enable the General Medical Practitioner to assist in the work of the prevention of ill-health with the local health authorities and when the Occupational Health Service is introduced, scope and opportunities will be provided to the General Medical Practitioner to assist in this service.

6. The salaries of Medical Officers of Health must be brought into line with those earned in other spheres and commensurate with the responsibilities which they carry.

7. The SMA considers that recommendations on the adequate remuneration of doctors and dentists cannot be made without at the same time making comparisons with the remuneration of other Health Workers, especially in the hospital services. This will reveal that they are often poorly paid compared with people with similar qualifications and training in industry. But the most important point is that the remuneration of all health workers must be so organised that it encourages team work within the service and higher quality in the individual.

APPENDIX

1. *The Provision of Health Centres.*

Recommendations:

- (a) The Government to provide the Local Health Authorities with enough monies to establish the necessary number of health centres in their areas.
- (b) The Local Health Authorities to set up ad hoc committees consisting of members of the Local Health Authorities of the Regional Hospital Boards and the Executive Council to plan and site these Health Centres in their areas.
- (c) Adapt available large houses or other suitable premises. Use available sites and build Health Centres with pre-fabricated units.
- (d) Adapt available Hospital Buildings, or use hospital land to provide Health Centres since most hospitals are situated in built up areas and are conveniently sited.
- (e) Existing personnel such as secretarial, nursing, and other ancillary staff now employed by the General Medical and Dental Practitioners should be able where suitable to enter the Health Centre Service.
- (f) Educate the people in the areas of the Health Centres to use them for medical and dental general practitioner services and also to understand how the health centre can assist prevention as well as cure. In the case of some existing health centres such as Woodberry Down no attempt has been made to explain the value of, and attract people to, the centre.
- (g) The Local Health Authorities to provide their health centres with domiciliary nursing and social welfare staff etc.
- (h) The Government to provide the Health Centres with enough money annually to maintain them adequately.

Examination of Witnesses

DR. D. STARK MURRAY, *President*

DR. H. JOULES, *Vice-President*

DR. D. KEER, *Secretary*

on behalf of the Socialist Medical Association.

Called and Examined

1. *Chairman*: This is the first public hearing the Commission have had and perhaps I should begin with a word or two as to procedure. I would like the representatives of the bodies appearing before us to understand that we would naturally wish to test clearly and thoroughly what they say as to facts since we are interested in facts first and foremost. If we do not test them there is no one else to do it. This does not imply either disbelief or hostility if we have to ask these fairly searching questions, and in the same way failure to pursue a point does not necessarily imply acceptance or that we think it is irrelevant. Any member of the Commission will be asking you questions, but I will explain that for convenience we have given the preliminary task of looking at the many submissions we have had from different bodies to two separate committees of the Commission. In this particular case Sir David Hughes Parry has acted as the chairman of the particular sub-committee, and so I shall be asking him to lead off on the questions on most of the paper's main topics.

Further, I would like to say that much of the evidence submitted by some bodies—and this applies to some extent to the Socialist Medical Association—is of interest but is strictly outside our terms of reference. Now we shall be asking some questions no doubt on some of the matters that are not strictly within our terms as a means of getting information that bears on those topics that are ours, but it must not be expected that in any report or recommendations we shall necessarily deal with all the questions about which we want to ask you. Might we start by asking you questions on the membership of the Association? In your letter some months ago you told us the Association consists of a full membership drawn from doctors and other health workers and associated organisations. Could you tell us broadly the numbers involved, the extent to which they cover doctors, what you mean by other health workers,

and the extent to which dentists are included?—*Dr. Murray*: We never have been a big organisation; we are a purely political organisation and we have always insisted that we must look at the health service as a whole, and therefore we take all health workers—that is to say medical, dental, pharmaceutical, opticians, nurses and other ancillary health workers who are recognised as being part of the National Health Service. We do not take the purely ancillary workers in hospitals and so on except as associate members but all other health workers we take as members. In addition, to obtain our literature and be in contact with us and ask us questions, we have as associate members other interested bodies such as trade unions, co-operative parties and so on who are in sympathy with our work. As to figures our full membership of health workers is just over 2,000, and of these approximately 500 are doctors and dentists. The number of dentists is small, only in fact about thirty for the whole country. The number of associations—personal and by organisation—is somewhere about another thousand, but the number of organisations whose membership is thereby associated runs into the usual astronomical figure of something over the million because of the number of trade unions who have large memberships and who are directly associated with us. The full membership is just over 2,000; we are affiliated to the Labour Party and our main work is done through the Labour Party.

2. That means about 1,500 of your full members are not doctors and dentists; they are physiotherapists, nurses and so forth?—Every type of worker in the health service as a whole is represented.

3. And this submission of yours is from your Council—let us say from the full membership rather than from the wider body with whom you are associated?—Yes. We never issue anything from a single point of view. We

try to make it cover all health workers and you will see a paragraph in our memorandum relating doctors' remuneration to remuneration of other health workers. I am just putting in a caveat that we cannot overlook that point in any discussions.

4. And you say that among the membership of the medical profession you include almost every category—consultants, specialists, S.H.M.Os, senior registrars, registrars, etc. Is that 500 broadly split between the main categories or is there a predominance, for instance, of general practitioners or of consultants?—At an ordinary council meeting I should say, so far as the doctor members are concerned, we are almost fifty/fifty hospital doctors and general practitioners.

5. *Sir David Hughes Parry*: I would like to take you through the memorandum that you have submitted and ask just a few questions upon it for help on certain matters. I take it that your main contention is contained in the centre of the introductory paragraph: that you advocate whole-time salaried employment for all in the health service. Is that right?—That is in fact our reason for coming to you on this matter as a political body and not as a trade union body, but we believe that if the principle of payment is not decided the Commission may not arrive at a correct set of figures. As an organisation we have always advocated a whole-time salaried service for everyone in the health service. Perhaps you would like me to elaborate the reasons.

6. In the memorandum you give three reasons. You say it is more economical, more efficient and conducive to a far higher standard of medical care. Would you take each one and elaborate for us?—There is the further point behind all this that we believe that we cannot run a service in which one particular group of the workers are paid by methods different from the other. On the economic point we have quoted here Titmuss and Abel Smith's calculations on the cost of part-time consultants, and it is from that particular angle we believe that a whole-time service would be more economical.

7. I do not think we have the actual references.—The Guillebaud Report actually quotes it, but in Abel Smith and Titmuss there is an appendix, Appendix D, which sets out their calculations on

this matter. The summary briefly is that in the present structure in which you have part-timers and whole-timers in the consultant/S.H.M.O. ranks in hospitals, it is at least one-third more costly per hour's work to have a part-timer than it is to have a whole-timer. The calculation is mainly based on figures which they obtained from the South West Metropolitan Region covering a very large number of specialists and specialties. Even after calculating a 33 per cent. difference they still say there are other factors which they have not been able to ferret out and which might make the difference even greater.

8. It would be fair to say you base that reason on the articles written by Professor Titmuss and Mr. Abel Smith?—We base it on our own general experience of the question but it so happens that they have crystallised it and given the only published figures which are available. It is very difficult for outsiders not doing the finances of the hospital service to dig this out.

9. You have no other evidence which you could put before us to help us?—No other figures; nothing else except, as I say, our general experience in looking at this problem and knowing all the different things which add to the cost of the part-timer in hospital service.

10. *Chairman*: Are you yourself in the hospital service?—Two of us, Dr. Joules and myself, are in hospital service, both at large hospitals. Dr. Joules is actually in charge of a very large hospital. Perhaps he would like to say what the experience is there.—*Dr. Joules*: There is little question, Sir, that for the amount of time made available by the consultant the expenses automatically go up as one passes from whole-time to part-time employment. I understand that you will be receiving detailed evidence on this matter from other bodies, but it is perfectly true that if from tomorrow I ceased to be employed whole-time and became part-time—that is took on 9½/11ths—I should diminish a little in salary but I should increase very considerably in payments for work done. First of all I should be paid for every journey to hospital. At the moment, of course, whole-timers are not paid for each journey to hospital. I should be paid for each domiciliary visit that is done and whole-timers are not paid until

they have done eight free ones a quarter ; and I should be paid considerably more for the teaching that I now do as a whole-timer. Thus one could go on with the inducements that we shall be discussing later which attract people away from whole-time service in hospital. If passing from whole-time to part-time succeeds, as those who transfer hope it will, the availability of consultants at hospital is automatically diminished.

11. *Mr. Guniake*: Is the claim that there would be greater economy confined to the hospital services or extended in your minds to general practitioners?—

Dr. Kerr: I am sure it is extended in our minds to general practitioners. It would not in our view be easy to establish an immediate economy in terms of general practice in the same way as we can establish it, at least to our own satisfaction, in terms of the hospital service, but there are some points I could mention here. The present method of service is notoriously unbalanced in the sense that there are errors in the lists leading to inflation of lists. If doctors were transferred to salaried employment this error would be entirely expunged. Secondly we believe that a salaried service would provide a stimulus for preventive methods under the health service and would lead to a rising standard of health, a saving on the curative service and a smaller loss of productive time. It is on these rather far-reaching principles that a salaried service for the general practitioner is a more economic one.—*Dr. Murray*: May I say something about the tax relief question? That is a factor which it is impossible for those of us who are whole-timers to calculate very accurately, but as one who was at one time doing private practice and is now doing whole-time, my own estimate is that with very little variation in my present arrangements, simply by dropping the amount of time I give in theory to the National Health Service, I could increase my income by something like £1,000 a year by making this change. That is from sitting down and working through my own figures and basing it on my own experience ; it might be worth as much as that for me to drop 1½ sessions and go part-time.

12. *Chairman*: May I ask Dr. Kerr one question. You said, I think, the elimination of inflation of lists was a reason for expecting economy if there

was a salaried service. The inflation of lists, as I understand from the Guillebaud report, does not in fact increase the cost to the Exchequer at all. Is that right?

—*Dr. Kerr*: I think as long as an Executive Council has to disburse money from the Exchequer for 105 per cent. of the population in its area, there must be some element of extravagance associated with this. At one time—I am not in possession of information to say whether it still obtains—the London Executive Council were responsible for payment of their doctors for more than the known population of London. When this is added to the fact that not 100 per cent. in any case would be registered with doctors this must entail an uneconomic method of payment. I would not wish to stress that as the only immediate factor in favour of economy that I could with justice put forward ; I would rather dwell on the long-term aspects.

13. I think that there is in fact a pool so that if it is spread over more people it is still only exactly the same amount of money?—That is perfectly true. But I still hold there is local extravagance even if it is only in terms of the sort of clerical extravagance in maintaining the lists at their proper level. It is still an uneconomic method of carrying out this service.

14. *Sir Hugh Watson*: Under the system of payment of doctors from the pool, over the whole country it cannot cost the Exchequer any more?—I would accept that point.

15. Could I ask Dr. Murray one question? You are basing these arguments entirely on the question of accounting?—*Dr. Murray*: Entirely on the actual money spent.

16. You know this matter of part-time service has been before several committees already, and you are familiar with what the Guillebaud Committee said about this particular matter. You know that while they came to the conclusion that no financial inducement should be offered to a man to be part-time, there were many benefits existing to the country by the existence of part-time consultants?—We are not implying that all the whole-timers are saints and the part-timers are not or vice versa. We are not making any implication about the individuals or the way they do their work. There are men on both sides of this fence who put their whole

hearts and souls into their jobs. We are not saying it would be more efficient because the part-timers do things the whole-timers do not do; we could all quote cases both ways. But from the point of view of the organisation of medicine—and this applies particularly in the cities and in London—the present part-time arrangements and the present mixture of private practice with part-time work in hospital still maintains the position which we had before the National Health Service that it pays a man to split up his work, to divide his time running backwards and forwards from a number of places. If he is to continue to attract private practice he must spread his net as wide as he can. Therefore it does not pay him as a part-timer only to have one part-time job at two hospitals; it pays him to have ten part-time jobs at ten hospitals so that he spreads his net as widely as possible. And the National Health Service pays for his travelling expenses. In the London area it is not unusual to have a session on one day or even half a day in the western part of London and have a session the same day in the south-east part of London; this must lead to a great deal of inefficiency. It also leads to inefficiency inside the individual hospital because you are never sure that any doctor will turn up at any hospital because say of fog or other travel difficulties. You are never able to organise the work of the hospital with such accuracy as you can with whole-time people who are known and expected to be on the spot. Looking at this as a member of a Regional Hospital Board as I did for some years, I was very much aware of the fact that at the smaller hospitals we were organising consultant methods simply to maintain part-time practice and not because it was providing the best service either for the hospital or the area. We believe that administratively it would be much more efficient to have everyone on the same basis. Dr. Joules might like to add to this. He has the job of organising this work and knows it in every detail.—*Dr. Joules*: I must say I approve of what Dr. Stark Murray has said. This splintering of appointments is quite fantastic. In the Ear, Nose and Throat specialty, for example, it is not unusual to have four or five specialists coming for one or two sessions a week into one comparatively small Manage-

ment Committee area. It is impossible in those circumstances to organise a large volume of work to be done effectively, and of course when one realises the expense of getting these eminent gentlemen to the individual hospitals the waste can be seen. As Dr. Murray says, the interruption in work that is bound to take place on many accounts—particularly with travel nowadays—will be very obvious to members of the Commission. In our own region we have roving members of the profession whose parish spreads from the centre of London to Luton, and they do a circuit which often involves up to 15 sessions a week on a part-time basis.

17. *Chairman*: I think I understand you are recommending not so much that there are too many part-timers, but there should be no part-timers at all, that everybody should be compelled to be a whole-timer?—*Dr. Murray*: No one should be compelled, but those who wish to serve the National Health Service should give their whole time. There is no suggestion that private practice should be legally impossible or anything of that nature, but those who elect to give their services to the National Health Service should give it on a whole time basis. Clearly in the specialty Dr. Joules has just mentioned you probably could have a hospital in the country in which a man would not give the whole of his time to one hospital but he might very well give it to one hospital group, certainly to contiguous groups without all this waste that there is at present. In my own hospital group I think we have six part-time Ear, Nose and Throat specialists who are all doing little bits at different hospitals. The work could quite easily be amalgamated and organised in a more efficient way.—*Dr. Joules*: It is interesting to note that under the present circumstances men doing part-time work and travelling long distances as some do, can do their full sessions by Wednesday evening—they have done their 9½ sessions by Wednesday evening.

18. Do you wish to add anything on this question of efficiency on the general practitioner side?—*Dr. Kerr*: Our views are based, as our document shows, on the organisation of general practice through health centres. We are profoundly aware of the difficulty of introducing a salaried service without some sort of central organisation of this kind,

and although the term "health centre" does tend to conjure up pictures of architecturally extravagant buildings, it is not our view that these are necessary to the service. With this fundamental premise that health centres are a desirable and inevitable progression to health, we take the view that to allow competition within the precincts of the health centre leads to negation of full efficiency of the services offered there. This is particularly true when I point out that the fundamental conception of health centre practice is the integration of the local authority and the general medical practitioner services. In this way some of the duplication of services which exists at present would be removed. A general practitioner who has a far closer relationship to his patients than any local authority doctor would play an immediately far greater part in such affairs as maternity medical services and school medical services. We take the view that to combine at the present time the local authority with the general medical practitioner services—the one a salaried service and the other a capitation payment service—would not allow the two services to co-operate and be integrated in the way we regard as essential. We believe that a health centre service is desirable, and indeed inevitable, but that full integration cannot be carried out as long as there is this differentiation in payment of doctors serving under the same roof.

19. *Mr. Gunlake*: Would this imply equality of lists?—There would be no lists. A group of doctors would be responsible for the whole population served by that centre, and no doctor would be credited with a list any more than under the present system a certain hospital officer is credited with a certain number of patients.

20. Would there be freedom of choice by doctor of patient and by patient of doctor?—Perfect freedom of choice. The same freedom of choice by the patient of his doctor and possibly greater freedom by the doctor of his patient, because at the moment the doctor attempting to establish his list is compelled to accept any or all sorts of patient willy nilly, and it is a rare doctor and a rare occasion which demands the removal of a patient from a doctor's list. Our view is that under a salaried service a doctor would be far freer particularly

in a professional sense and not merely as a question of personal taste—to pursue the interests in medicine which at present he is inclined to drop. Under the present set-up, of course, the general practitioner has to know everything; he may still, but a doctor under health centre practice could know a little bit more about one particular branch.

21. If there is freedom of choice by patient of doctor, how do you ensure reasonable equality of work as between one doctor and another, assuming that their salaries are on a par?—Any person in an emergency is perfectly happy to accept any doctor who happens to be available. I am one of a partnership of four in a very large practice in central London; there is considerable interchange between the four doctors—three men and one woman—and it pleases me to think we all have different views. There is very happy competition; there is already the germ of different interests. My own special interest is children and one of my colleague's is in psychiatry. This sort of organisation is allowing us already to pursue interests of these different sorts. The question of freedom of choice by the patient is no new one. Many patients have no freedom of choice. Under the health centre system there would be the same sort of freedom of choice with the same sort of spread of work as we find in practices in under-doctored areas and of course in the hospital service.

22. *Sir David Hughes Parry*: It is of course a fact that the introduction of the health centre practice would involve an entire change in the character of practice as at present?—Very considerable changes, all of which we would regard as improvements. I think I would have no reservation about that. This assertion is borne out by experience in established health centres: not, unhappily, in all of them but certainly in those which approximate to our ideas. The doctors who went in open minded without being committed ideologically are now unreserved in their praise for the practice. One has said this is the only intelligent method.

23. This may very well be outside our terms of reference.—I do appreciate that, but it is so fundamental to try and explain why we are pursuing this object of a whole-time salaried service in general practice and what its introduction would involve. The idea of a whole-time

service would be null and void in the present set-up.—*Dr. Joules*: We do hope in this evolutionary community that such advances as are made in methods of payment, etc., will assist in what we regard as the attainment of the most desirable end eventually, and I am sure that we should not be out of order in asking you to assist us in that direction.—*Dr. Murray*: May I add two points? If you look at the latest figures in regard to partnerships in the medical profession you will see that the changes *Dr. Kerr* has indicated in a practice like his own are taking place throughout the country. So far as general practitioners are concerned, there are fewer practitioners in single handed than in multiple practice, and the number going into large practices is increasing annually. These are the latest figures in the Ministry's report, but if you go back to the British Medical Association's Plan Report of 1942 you will find an adequate description of a group of general practitioners in a health centre which in fact emphasises every point which *Dr. Kerr* has made. I am only saying that to show that while the system may seem revolutionary, it is evolutionary because you can find it in existence as far back as 1942 inside such a body as our opposite number, the British Medical Association.

24. Can we go to the third reason, that is "conducive to a higher standard of medical care."?—This is a very short phrase to cover a great many points. First of all there are all of the so-called ethical doctrines of the medical profession. We are tending to a system which strives for maximum co-operation, which replaces the individual by the team and creates co-operation within and between every organisation in the health service. So long as you have a great variety of methods of payment and so long as you have this part-time business, you cannot get in the hospital service—and on a capitation basis you certainly cannot get in general practice—the full co-operation between doctors and between other sections of the health service. We agree that if you do anything to encourage that team spirit then you will be raising the standard of medical care. We think it is quite wrong that a profession such as this should need to have business rules (ethical rules of the profession which are in fact business rules), to try

to prevent competition becoming too fierce, to try to prevent people from advertising in order to get more patients. It has nothing to do with ethics; it is a purely business arrangement to prevent competition being so fierce as to upset all the relationships in the profession. It has one very big failing because in so far as you have such rules you cannot ask the medical profession to play its part in the education of the public in regard to health. Every doctor who attempts to give education to his patients—and above all to citizens irrespective of whether they are his patients or not—may be challenged and may lose his place on the grounds of advertising. And this we believe is one of the things which will stop preventive medicine from doing a big job in this country. All doctors must be free to do their education work with all citizens of the country, and you cannot do that as long as you have competition and as long as you have to have rules to restrict competition. Inside the hospital service the operation of the team spirit does lead to a very much higher standard of medical care than if you have the service broken up into small units. This is recognised, in teaching hospitals, for example, where you already have unit systems and people do work in teams. It is recognised in large hospitals where you have whole-time workers able to give the whole of their attention to the work inside that hospital without any of the outside distractions and splitting up of their work which we have already mentioned. A sense of loyalty should be built up and if some of the things we have said in our memorandum about promotion and about the new structure for the consultant ladder were also put into operation, we feel that it would lead to the development of a team spirit in which loyalty to the hospital and to the hospital service would, with all the other points I have mentioned, lead to a much higher standard of medical care.

25. We have evidence from some of the consultant bodies in which they emphasise the value of competition as a sort of incentive to a better quality of work. You obviously do not agree.—This is quite false. You want to protect a system, therefore you think up the excuses and this is one of the excuses you think up. There is

nothing more conducive to a higher quality of work than knowing you are there to do a job and that you have not to run off and go somewhere else. If you take my own branch, the laboratory. The South West Metropolitan Regional Hospital Board has passed a minute that pathologists must be whole-timers so that they can give their whole time to this very important branch in their own laboratories. There is no evidence from medical literature or medical history that to be a part-timer leads you to make greater discoveries or to do greater things than whole-timers have done and are doing. As the standard of medical care has risen as a whole—as it has done over the past half century—the whole-timers have gone up with that rise in standard, and if we wanted to have a competition—if we wanted really to start to put up teams, we could quite easily produce a good one in any specialty of whole-timers against a team of part-timers. We do not like that sort of thing, but we are quite sure that this idea of competition producing a higher standard is wrong. When you are operating on a patient the fact that somebody is doing it much better who happens to be a part-timer does not make you do it any differently.

26. *Sir Hugh Watson*: You have stressed your views as being purely political. You represent 470 doctors?

—*Dr. Kerr*: I do not claim to represent only the doctors but the Socialist Medical Association.

27. The association represents 470 doctors?—Of one kind or another, yes.

28. As *Sir David Hughes Parry* has said we have it in evidence from consultants that in their view the element of professional freedom given by being part-time greatly increases the sense of professional efficiency and the independence of the individual consultant. From that you dissent?—I do, Sir. It is derogatory to suggest that at any time a doctor would ever do less than his best for his patient.

29. I am putting this suggestion to you in an endeavour to test the statement. What they say is "The element of professional freedom given by being part-time greatly increases the sense of professional incentive and efficiency and the independence of the individual consul-

tant".—*Dr. Murray*: If I may answer it, they are making another implication here which is entirely false. They are implying that to be a whole-timer is to lose professional freedom, and that is quite untrue. The whole-timer gains professional freedom. He gains enormously just because he is able to give the whole of his time and attention to the job in hand without any distractions. This is an implication which we and many in our professional organisations could not accept at all. Do not forget we are also members of these other organisations and in those organisations we know the majority opinion though it is far from unanimous. We have protested in other places at such implication.

—*Dr. Joules*: I think it is desirable, though, as some evidence has been given from another quarter that the present minority point of view should be stressed because a minority point of view not infrequently becomes a majority point of view before too long. I must say I resent somewhat the suggestion that in my own professional conduct I should have received a greater incentive and achieved greater efficiency if I had not chosen to remain whole-time at considerable loss to myself and status in my profession. May I refer to another aspect of hospital life which is adversely affected, I think, by the part-time, and particularly the private practice aspect of our life—and that is that we do have two standards of institutional treatment in this country—one for those paying privately and one for those in wards in hospital. There is no doubt whatever that our hospitals have not progressed as they should during the last ten years because, in the main, of the lack of capital money. The conditions which the non-paying patients have to put up with in hospitals are not those which we should be content with in 1957. This results in part, certainly, from the fact that an influential part of the community does not have to face these conditions and knows little about them, nor do the many members of the profession have to treat the more demanding members of our society in adverse conditions. I would refer you particularly to conditions in the mental hospitals and I would tremble to think what would be said if any of the present paying patients had to receive treatment within mental hospitals.

30. *Chairman*: I must ask you, Dr. Joules, to try to keep a bit nearer our terms of reference which relate to the pay of doctors.—Yes, but we were asked about the question of efficiency. I do think that the part-time practice has perhaps deflected many doctors' attention away from the conditions in hospitals rather more than it would have done had more been on a whole-time basis. That is the only point I wished to make.—*Dr. Murray*: May I refer to Sir Hugh Watson's point about this element in the professional field? If in fact those who have said this are seniors and I take it are consultants and really meant it they ought to look at the structure of the hospital service which they in fact think is the best structure. In our hospitals we have to-day a very large number of people who are already whole-time salaried officers. No one in the senior professional organisations has ever suggested, for example, that below the status of senior casualty officer anyone should go part-time. There are throughout the country senior registrars who for some reason or another are part-time, but by and large the bulk of people employed in hospitals are whole-time. If you look at the latest report of the Ministry of Health you will see that going down as far as the registrar grade 64 per cent. of work done at hospitals is done by whole-timers. If in fact an element of professional freedom by going part-time would improve the standard then these people ought to believe that registrars, senior registrars, casualty officers and so on should become part-time. In fact they do not say so. They say you can only get an efficient service if they are whole-timers. If you include the lower grades then at this moment 74 per cent. of the work—this is still allowing the doctors' travelling time to be counted as work because I have not made a calculation to take that off—then at the moment 74 per cent. is done by whole-time doctors. The principle is there; it has been accepted as ideal. The only group who in fact do more hours on hospital work as part-timers than whole-timers are the consultants, and that is only a relatively small proportion of the total.

31. *Sir David Hughes Parry*: The last sentence of the introductory paragraph states:—

"The arguments are so powerful that it is clearly wrong to perpetuate

a method which encourages people to take part-time employment at greater cost to the nation."

I take it these are the arguments you have now put before us? There are no further arguments in any written statement or anything to which you would like to draw our attention?—No, I do not think so.—*Dr. Kerr*: On the higher standard of medical care from the practitioner point of view, may I refer to four factors which I would regard in general practice as in very considerable need of improvement? The first is the question of better distribution of doctors. The Willink report referred to the improvement in distribution of doctors, but none the less it does point out that 25 per cent. of the population of this country, only a small proportion of which surprisingly enough is in rural areas, are still in under-doctored areas. In our view the opportunity to take a salaried post in some sort of health centre would enable doctors who find it at present impossible to establish themselves, to establish themselves in these under-doctored areas more rapidly. Secondly the question of post-graduate study in general practice. In a salaried service we would expect that there would be far better organisation and opportunity and incentive to at least keep himself up to date. Under the present capitation system there is no obligation on the general practitioner to pursue post-graduate study—and I would in parenthesis pay tribute to the work done by THE COLLEGE OF GENERAL PRACTITIONERS in stimulating this interest. Opportunities are provided but not all are taken advantage of, and in any case they are too few. We would expect post-graduate study at health centres to be improved by the facilities of a whole-time salaried service. More important, I think it is no secret that the system of record keeping among the vast majority of practitioners is entirely farcical. The form provided by the Ministry is in any case not the best design, and the expense involved in keeping clerical and reception staff available means that unless the health centre type of practice is established, records are never kept adequately. At a centre with a whole-time service we expect the standard of record keeping would add materially to the standard of medical care. Further, the opportunities for original investigation and research among

general practitioners would be immeasurably extended simply by virtue of the fact of better record keeping. All these things we view as the inevitable outcome; improvements stemming from a whole-time service practised as we see it. This is particularly germane to your terms of reference—if it falls not actually within them—in so far as a better standard of health would result.

32. *Mr. Bonham-Carter*: I have been listening with very great interest—although no evidence has been put before the Commission as yet on the point, I have been led to understand since we have been sitting that the medical profession holds very strong views about the effect on the doctor/patient relationship which they claim—correct me if I am wrong—that a salaried service would destroy. I am not clear in my own mind, on what that is based.—This objection was, of course, raised when the National Health Service was introduced, namely that by the introduction of a state service the doctor/patient relationship would be disrupted. Perhaps it is not entirely fair to argue by analogy but we have proved that wrong. In fact the doctor/patient relationship has been preserved under the capitation system and our view is that there is no distinction between the two systems, namely the capitation system and the salaried service system, in so far as it affects the doctor/patient relationship. We see no logical reason for supposing there would be that difference.—*Dr. Murray*: These arguments were brought up in 1911 and they have been brought up constantly about the health centre practice. But if the Commission likes to have someone from the William Budd centre at Bristol or one of the Derbyshire House people or the Stranraer people, you will find that after years of experience they are saying their relationship with patients has improved. It depends so much on the doctors. The doctor will establish the relationship and given good conditions it will improve.

33. *Professor Jewkes*: May I come back to the question of full-time and part-time consultants to try and get the facts. Is it your opinion that private practice by consultants is on the increase?—*Dr. Joules*: We have; I think, no evidence on that point, Sir. From my own observations those who have chosen to pass or who have been finan-

cially induced to pass from whole-time to part-time practice have had very little difficulty in collecting quite a considerable private practice, but I have no statistical evidence with which to help you.—*Dr. Murray*: This varies enormously from district to district depending on the services which exist.

34. *Chairman*: And from specialty to specialty also?—Yes, but if you have already a very good service given by a hospital the amount of private practice diminishes. The moment your hospital service comes under any suspicion or any doubt you may be able to maintain private practice. I know this from my own area which is an area from which you would expect a fairly large number of people still to seek private consultative service; but in my own specialty we give a domiciliary service irrespective of whether the patient wishes to be treated as a private patient or as a domiciliary under the National Health Service. That is to say that although I am prepared to go out as a private consultant, the fee I get goes into the National Health Service. In that sort of service the number of requests from people to be treated as private patients has practically disappeared. At one time I used to be able to say "We collect so much in fees; it is offset against our expenses for which we ought to get credit." I am no longer in a position to say that. It still remains; it goes down to a very very low figure indeed.—*Dr. Joules*: Waiting lists and waiting times at hospitals I think are one of the things which induce more people to consult in private than otherwise would do so. There is no question about that and unfortunately in some areas waiting time is quite deplorable—up to six months for an X-ray, and up to 12 weeks to get an appointment to be seen in the hospital outpatients' department.

35. I know conditions vary between specialties and between different parts of the country. I am trying to get some idea of the trend. You say in your document that the expectation that there would be a marked diminution in private practice by consultants has in fact not proved right, so we can assume there has been no marked reduction in the amount of private practice done by consultants. But in your opinion do you think the financial scales are weighted towards encouraging part-time consultants as against whole-time consultants at the moment?—*Dr. Murray*: The scales

are very definitely weighted. Where you have part-timers and whole-timers working alongside each other both prepared to do domiciliary visits, for example, the scales are weighted because the part-timer will be called out by a general practitioner on Monday to see one of his private patients and on Tuesday to see a National Health Service patient. Your whole-timer will only be available for National Health Service patients and within the same specialty the general practitioner would then have to go to two men. The general practitioner will tend to use the man who gives a full domiciliary service to both private and National Health Service patients within his specialty and that is the part-timer. This is not a fault but a natural thing. The part-timer who gives a service in an area both for private work and domiciliary visits will still get the bulk of the domiciliary work to do, even where a whole-timer is available who might even be recognised to be superior in some ways.

36. Arising out of that, short of a completely salaried service suppose in fact one had to go on with this division between whole-time consultants and part-time consultants—is it your opinion that ideally an attempt should be made to produce earnings which are equal for part-time consultants and whole-time consultants?—No, we think you should fix what you regard as a suitable payment for the whole-timer subject to all the factors being taken into account, and that the part-time salary ought then to be broken down from that and should contain none of the present part-time inducements. Although in theory that is what is done, in fact all the present inducements for part-timers put them into a quite different category.

37. You consider the part-timer is over-weighted?—I do not think the part-timer should ever be able to get more from the service than the whole-timer would get. In addition to that we expect that the amount which is involved in income tax relief and so on will also be taken into account so that even that is covered.

38. *Professor Jewkes*: I was merely asking were you prepared to go further—thinking in terms of total earnings—that ideally you should try to make some arrangement by which the two groups were earning about the same?—As an

interim measure in a service in which there are both types?

39. Yes.—I think so long as you deal fairly with the hospital side of things you will still have to believe that the man who earns something outside by private practice may with luck in certain areas and certain specialties go to very much higher figures. I do not think we would ever attempt to suggest a structure in which you would ensure any whole-timer got the maximum that any part-timer could; but so far as the National Health Service is concerned there should not be this variation.—*Dr. Joules*: In our view the hospital service is paramount and we should do everything to ensure that people are not led away from that service to other pursuits.

40. *Chairman*: When you say that the hospital service is paramount, does that mean you think the general practitioner should rank rather lower?—No, I am sorry I was not referring at that stage to general practitioner work. I was referring to the private practice of the consultant as compared with his hospital work.—*Dr. Murray*: We were not making that sort of point about the general practitioner. We regard the general practitioner as a specialist in general practice and if there are going to be responsibility allowances which we have mentioned in our memorandum they would apply equally to all sections of the profession, because we do not make that distinction in our minds.

41. There is this distinction—that the hospital service is basically a salaried service and the general practitioner is not a salaried service?—Yes—apart from that.

42. Do I gather you feel that if the general practitioner service became basically a salaried service that it should come in on about the same sort of terms and spread as is now adopted for the hospital service?—Yes.

43. May I ask whether you have any reason to think that anything more than a small minority of the doctors in general practice would welcome a compulsory whole-time salaried service?—I do not think that they would welcome a whole-time salaried service, but I think, subject to the terms and conditions being satisfactory, they would accept it and would work it.—*Dr. Kerr*: If I may intervene, the use of your word "com-

pulsory" particularly in the present context is not in accordance with our own views. We would not welcome a compulsory whole-time salaried service any more than we welcomed compulsion for the National Health Service in 1948. We would like to see the beginning of a whole-time salaried service and we are convinced the advantages would become so apparent—always provided the remuneration is adequate—that many doctors would very rapidly accede to this method of practice. So far as the present climate of opinion among doctors is concerned, my own view is that there is a much greater readiness to accept the idea of a salaried service than is commonly held by those who have a vested interest in preventing it. I would point out to the Commission that the present system of payment by capitation fees means to the individual that they are getting something fairly closely approximating to a regular salary. Firstly, he can be paid now by monthly instalments if he so chooses. Secondly, and this is based on my own experience in a busy practice and close touch with my colleagues, the variation in size of list, which is the bulk factor in the doctor's income, is very small—commonly as little as 2 per cent. per year. In other words from year to year once a doctor is established he can look forward to a fairly constant level of remuneration from the size of his list. On these two premises I would say that the transfer from the capitation fee system of payment to a whole-time salaried system of payment would be relatively painless. Although there is a good deal of antagonism within the profession there is, I am convinced, an unrealised pool of sympathy towards this idea.

44. *Mr. Bonham-Carter*: Does the sympathetic element come from the younger members of the profession?—Yes, undoubtedly so.

45. *Mrs. Baxter*: May I ask a purely practical question? I think Dr. Murray mentioned income tax reliefs. I wondered whether the Socialist Medical Association produces comparative taxation expenses—whether you have worked this out in any way comparing the type of expenses between, say, the service of an EAR, NOSE and THROAT specialist part-time and whole-time for a given number of people, and whether there is anything comparable in type of expense in a group practice such as Dr. Kerr's for a con-

siderable number of people under the National Health Service. Are there any figures you could let the Commission have?—*Dr. Murray*: On the consultant side we certainly have no figures. I hope the Whole-Time Consultants' Association, whom I understand you are seeing today, will be able to produce some figures, but it is a really quite impossible task for us to collect them. Perhaps your questionnaire will find some, otherwise it is quite impossible. On general practice it would be possible to get a practice like Dr. Kerr's to provide figures and the figures have been published for one or two of the health centres.

46. You have been very good in giving us your impressions of comparative economies, but I wondered whether there was in fact anything more?—You could obtain the health centre figures for those in existence. It would take quite a bit of analysis, however, because as they are local authority centres there is an element of subsidy.—*Dr. Kerr*: I have had occasion to discuss this very question with an economist recently, in an attempt to arrive at some sort of figure—the kind you are asking for. In fact, of course, it is impossible to arrive at a basis of comparison simply because you cannot knock out all the variables. The only publication which I could refer you to—although I do not think it would give you much guidance—is the London Local Medical Committee's comparison of health centres with a well-organised group practice, and also of a single-handed practice. This does contain the general principles we are trying to bring out, but unfortunately it does not get down to the more sordid question of cost.

47. *Sir David Hughes Parry*: Can I take you on to another matter? What do you think the relationship should be between the salaries, say, on the general practice side and salaries on the consultant side?—*Dr. Murray*: We have not really discussed this, as an association. You see, as soon as we get to actual salaries and figures we stop discussing. The fact is that we are not a trade union—and we have been severely criticised by trade unions, including the B.M.A., which some of us regard as our trade union—for venturing into this field; and therefore we have not in fact put anything in this respect into our memorandum.

48. *Chairman*: But you regard the two branches of the profession—general practice and the hospital service—as being roughly of equivalent standing?—Yes.

49. That part of it is clear, I think, but at the moment there are two quite different systems. Therefore are we right in assuming that you would expect the spread of earnings to be rather similar in the two branches?—Yes. We would prefer the system which would enable a man to choose what he wants to do and not a system in which any financial incentive was of such an enormous amount that it would out-weigh his natural inclination to do a certain type of work.

50. How would that affect the relative need of more people in one branch than another?—That will be governed by other factors.

51. I wondered whether that was itself a factor?—*Dr. Joules*: I think it is desirable that that point of view should be taken into consideration by the Commission at this stage. There is no doubt about that.

52. And I gather that you feel that the present system means the part-timers, in relation to the whole-timers, earn too much?—*Dr. Murray*: In relation, yes.

53. You feel there is a too-ready financial inducement to people to go into part-time work?—Very much so.

54. *Professor Jewkes*: And you think the general tendency is in that direction, do you?—There is a tendency for people to go part-time. It is a small tendency, but something like 100, I think it is, changed over last year from whole-time to part-time.

55. *Sir David Hughes Parry*: Perhaps *Dr. Joules* can help us on this, because he has come from whole-time to part-time, is that not so?—*Dr. Joules*: No, I am still whole-time; but I must say it has happened in recent months that consultants have been heard to say, "If it were not for my children, I would not continue on this part-time basis that I have taken up." It is not always such an acceptable thing for a consultant as it is made out to be.

56. Can we now move on to an entirely new subject? You say in paragraph A.1 (c) that Merit Awards

should be abolished. We would like to hear you enlarge on that. There are two matters there that we are interested in—the awarding procedure, that is, the practice of awarding, and the method of awarding. I should like to hear from you an elaboration of your objections from the two different angles.

—*Dr. Murray*: You have, in bringing out these two points, of course, touched upon the reasons. We are not attempting to say that there is no one, and never will be anyone, who has not achieved something in the Health Service that should not be recognised. Just as there are Nobel prizes for people of international repute, so there might be occasions on which a Regional Hospital Board or the Ministry of Health or anyone else might feel that someone had earned a reward for some particular type of work. What we are saying is that this system of arbitrary awarding and the giving of powers to a group inside the profession to give a secret award is entirely wrong. To begin with, of course, we have financial objections, because the merit award system was more or less pushed on to the Ministry of Health by a set of figures which were entirely false. When we said so at the time, we were spoken to rather rudely by those who had produced those figures. The Spens Report says that in Great Britain, if I remember rightly, there are 1,764 consultants; if you give one-third of them a merit award, on those figures, it would cost something like £300,000 per annum. We said at the time that this was entirely wrong—there were more consultants than that in the country—and that it would in fact cost the country something like £3 millions per annum. There are now 6,500 consultants in the National Health Service; and merit awards are costing the country something between £2 millions and £3 millions per annum instead of the £300,000 which was first spoken of. Something which was as much wrong as that in its basic figures was wrong from the start.

Secondly, we object to the procedure by which these extra payments are awarded in secret. We are not saying that the Awarding Committee are not, like yourselves, fair-minded people who try to do their job well, but we do not believe that a central committee can possibly have looked at and examined the work of all the people who might

be eligible, or even have been able to reach a conclusion on this point. Again, we do not like a system in which the public is unaware of how its money is being spent. If you were to continue a system of merit awards, we would like to see it as something which would attach importance, in the public eye, to the hospital and to the individual. We think that if it was known in an area that certain members of a staff of a hospital were in fact in receipt of higher pay than others because they were better people, then it would have a marked effect on public opinion in regard to the hospital service. At the moment the public know nothing whatever of this. They do not know the quality of the consultants in a hospital; they do not know, as between one area and another whether this is a good area for consultants or whether this is a bad area for consultants. We think if you have to have this system, it should be an open system. But in fact what we have suggested is that it should be abolished in its present form, and that some type of responsibility allowance should be introduced; and that this should be usually related to the particular post, whether it was a higher clinical post or a higher administrative post, rather than to individuals. It is true, of course, that in some particular cases, you may find that the post and the individual might be inseparable and you might, on occasion, find that the posts had to be altered because you no longer had an individual who could in fact be appointed to that post; but we think it should be a responsibility allowance for doing a particular job, and that it should be publicly announced.

57. That would tend towards rigidity, though, would it not?—We would hope that it would not become so rigid that you could not in fact vary it from time to time. There is, I believe, in the educational system, already a method whereby an education authority has a certain amount of money which it can in fact use in this way and can vary from time to time. For instance, if they have said, "There shall be such and such a post here"—it does not have to stick to that for ever and a day. It does not have to refer to a central committee, but can vary these things as it wishes.

58. You used the word "central" in relation to an awarding body. Is it central? I thought there were representa-

tives from different regions who advised on the matter.—*Dr. Joules*: They are quite unknown, Sir. They may be individuals who are picked in some way and who in fact do advise, but this has never been made public.—*Dr. Murray*: I think a practical example is useful—perhaps I should have said that at least two of us have a minimal vested interest in this matter. At my own hospital we have a particularly good medical staff committee, and we are really capable of sitting round and talking about a problem of this nature quite objectively, and of coming to a reasonable decision. For instance, if we were asked about this point we could, with perhaps a little difficulty and some heart burnings, pick out the people who we could advise as being at least the people we considered to be senior. You see, we have never once been asked. As a committee, we have never even been told that these awards are to be made. We have never had any opportunity of revising the list. We sit there and we do not know which of us has a merit award and which of us has not. So we have no means of judging this situation at all. If one has a member of one's staff whom it was desired to recommend for a merit award, I gather one can write to the Ministry of Health and get a form to fill in; but there is no more to do than that. There is no machinery for asking collectively at the hospital.—*Dr. Joules*: I would like to point out that these awards are not available to research workers in many spheres of work. They are not available, I think, for administrators and such—which I think is most unfortunate, because our profession lacks, or is likely to lack very shortly, capable medical administrators—and they are not available for those who are doing preventive medicine. In fact, the system is geared to therapy, and not to the better aspects of medicine—those which some of us consider will in the future result in the diminution of the amount of treatment to be done. Therefore we would urge that research workers, those doing administration—which after all in a Service must be very seriously regarded—and those who are largely responsible for preventive work in the country should have the same access, which I do not think obtains at the moment, to the recognition of merit, whether it is financially rewarded or not.

59. *Mr. Gurlake*: You are in favour of responsibility allowances related to the post. However, on page 6 you make the suggestion, as regards general practitioners in health centres, that there should be a system of payments for special skill and responsibility. I would like to ask whether that distinction is intentional or not. How would you measure special skill?—*Dr. Murray*: I think it really was intended. We are aware of this difference in the wording of these two sections, but to try to keep the document as concise as possible we have not expanded it. The reason for the different wording in the case of special skill in the health centre and general practitioner services is that if you take eight or ten general practitioners they will tend to develop their own skills, which they will recognise among themselves. They might have someone in a health centre doing a special job for that reason, and he might get an extra payment because of it. In a hospital you are appointed because you already have a special skill—you are, for example, appointed as a surgeon because you are already in possession of that special skill. Therefore we included the word "skill" here to bring out the fact that, although a general practitioner is not expected to have special skill in any direction, some general practitioners may develop such skill.

60. Special skill, in that context, means skill in a speciality rather than ability, if I may put it that way. Is that right?—*Yes*.

61. *Chairman*: The merit awards are enjoyed by about one-third of all consultants?—*Yes*.

62. Does your responsibility allowance suggestion infer something approaching the same proportion of all those getting something more than the basic average? Does it allow for two or three different levels of award or not?—*I think there would probably be different levels, but I was asked about rigidity, and here is where we would like to get away from a rigid formula.*

63. I just want to know approximately. Would you think it would be about the same number?—*I think it would tend to be less than the one-third, looking at any particular group that one has in mind. At the moment with the one-third, there is a good bit of squeezing at the lower level to bring people in; if*

we were doing it on a narrow basis, I do not think it would necessarily bring in any more. I think it would be less than the present figure but perhaps not a great deal less.

64. As regards general practitioners who do not normally progress from a post of lesser responsibility to a post of greater responsibility, as compared with consultants going from one hospital to another, you would need a different system, would you?—*We were thinking of responsibility within a health centre, and particularly administrative responsibility. If the health centre has already a fairly large number of doctors, someone has to do medical administration and take responsibilities. These would be recognised by his colleagues; and in fact he would probably be nominated by his colleagues. That would be the way in which you would achieve higher remuneration for greater responsibilities. That would apply to health centres, and the number to whom it would apply would depend on the number of health centres that one visualises as being necessary.*

65. You want the general practitioner to have the same opportunity to earn rather more than the average as the consultant has?—*Yes. We want to see recognition of any skill which a general practitioner may have developed himself.*—*Dr. Joules*: The full eligibility for merit awards, as we have suggested it, might not vary much, but the percentage would be lower.

66. I do not think I have quite followed that.—*Well, Sir, the field would be enlarged to include certain people whom we would regard as being due for recognition of merit, such as the ones I have mentioned—those doing research work, those doing preventive medicine and those doing administration.*

67. I see. As regards the sort of scale, do you visualise something of the order of 80 per cent. on top of the basic salary as at present?—*Dr. Murray*: Again, I think it depends on what your incremental ladder is. If you have, as we suggest, a different structure for the incremental ladder, then I do not think you need go up to a top which is the equivalent of the present whole-time top.—*Dr. Joules*: I think the difference is too much for the distinction which is to be found in hospital work; this distinction has tended to be related to

aspects of professional work outside the immediate activities of the hospitals.

68. But since there is no merit award paid in respect of any part of the Service outside the consultants, would a reduction in the top level induce the consultants to go more readily outside the Service, if they had the opportunity?—I am not sure whether you are envisaging a total reduction of pay; I was discussing differentials within the actual salary scales you are devising.

69. So was I. There is no merit award paid for the part of a part-timer's work that is outside the N.H.S.?—No.

70. And you say the very top man is overpaid in relation to the others?—I said the differential was too great.

71. It is the same thing—in relation to the others.—Yes: It is an invidious distinction, a too-invidious distinction that is made financially, from my own observations of hospital work.—*Dr. Murray*: Another anomaly, talking about it being invidious, is that in the present structure it is possible for an assistant in a department to be in possession of a merit award while his chief, who is in control of a department, has not got any merit award. There are quite a number of such cases; and as it is done behind people's backs and without anyone knowing except someone who perhaps happened to see it in a minute somewhere, it really produces considerable difficulties.

72. *Sir Hugh Watson*: Apart from your criticism of the method by which it is done, by and large would you quarrel with the results? Would you say that the awards have gone to the wrong people?—We do not know, Sir; there is no information except for little snippets which we pick up. We have never been shown a list, we have never been able to look at a list and try to make any assessment. As I say, it could be, in my own department, that my deputy had achieved a B merit award while I had achieved none. I would not even know.

73. *Sir David Hughes Parry*: My next point concerns your proposal 1 (c)—you mention two incremental ladders, and then you talk about a diversion. There are those who are going up higher on the hospital ladder and those who are

going to transfer to the general practice ladder. That is right, is it not?—Yes.

74. Do you suggest, in the first instance, that everyone who is going into general practice should have gone as far as the Registrar stage?—No, we are not implying that everyone would necessarily go to the Registrar stage. We think that those going into general practice might very well be recommended to go through the equivalent of a Registrar stage in general practice. We have not elaborated on this because we thought you would take it up on the subject of assistantships in general practice. We would like to see those who have done a certain amount of hospital work and have decided to go into general practice—into health centre practice—getting something equivalent to the hospital service in the way of training.

75. I had an impression—and it was obviously wrong—that you were suggesting that all should go up as far as the Registrar grade and then that those who fail to get up further on that ladder might be diverted into general practice.—*Dr. Joules*: No, Sir, but we do feel that there is much virtue in as many general practitioners as possible getting all-round hospital experience. That was not possible before the introduction of the Service. We envisage too, Sir, a modification or possible modification of a number of Registrar posts, particularly in peripheral hospitals, which would fit men for general practice much more than Registrar posts do now. It is possible that a distinction will, and must, grow up between Registrar posts in teaching hospitals and Registrar posts in peripheral hospitals, where we hope that there will be a co-mingling of hospital experience with general practice experience. We believe the post of Registrar should not indicate an automatic passage to consultant work but that it should, too, facilitate passage to general practice, which is not the case at the moment. As I am sure many members of the Commission know, the more hospital experience and the more scientific hospital experience a man has had, the less opportunity he has of getting into general practice at this moment, which I think everyone will agree is unfortunate.

(The proceedings were adjourned until the afternoon.)

76. *Sir David Hughes Parry*: In paragraph A.1 (a), you say that the basic salary of each grade should be related to the cost of living and reviewed annually. You say two things there—related to the cost of living and reviewed annually. We wondered what you had in mind and what sort of table or category of things were considered in regard to the cost of living?—This phrase, as the Commission will appreciate, is a point of contact with other organisations in the profession. On the question of how remuneration is to be calculated in regard to Spens—who attempted to fix a basic figure—we felt we had to indicate that in general it had to be based on some sort of calculation that did relate it to the cost of living. Now what cost of living implies depends in fact on what sort of factors this Commission takes into consideration in fixing the remuneration. If you take any of the things which apply to the medical profession and do not necessarily apply to other professions, and you make allowances for them, then the ordinary cost of living index, as used by other trades and professions and other governmental committees, would probably suffice in spite of the criticisms of the cost of living index which we would not take up time with here. Once it had been agreed that there was such an index, we could use it. If, on the other hand, the remuneration of doctors does not take into full account all the different expenses which they have and which do not necessarily apply to other trades and professions, then that cost of living index would have to be a special one, taking those factors into account. In that case it would have to be reviewed by a special body set up for that purpose. We have not defined that at all because we thought it would be something of a governmental nature, with economists, doctors and perhaps administrators represented on it. Normally one would have said that you could go to the Whitley Council for agreement, it being an accepted system of negotiation between the profession and the Ministry of Health, but that is difficult in view of recent developments.

77. In thinking of an appropriate reviewing committee have you in mind a particular set up existing for any profession or any trade or industry?—No, Sir. There are a number of people,

and indeed there is even one section in the Health Service, who have cost of living increases according to the normal Ministry of Labour cost of living index.

78. *Chairman*: Which section is that?—The Ancillary Staffs Council. They have received increments based upon cost of living.

79. To what sort of level?—The Ancillary Staffs Council only applies, of course, to the non-professional workers.

80. Weekly-paid people?—Yes. Claims go through the Whitley Council, but it is usually pretty much on a formula agreed by both sides.

81. *Mr. Gunlake*: Could I ask whether your advocacy of a close relationship between the cost of living and salary is based on the Spens report, or is it your view that everybody has a right to have his remuneration altered at any moment?—Rather the latter than the former. We are aware of how much it was taken into account by Spens, and we think the principle should be applied now. We have always advocated that most payments in the national economy should be thus related, and, of course, we strongly advocate pensions and things of that nature being tied up with it. We feel the principle is one that should be general.

82. *Sir David Hughes Parry*: In paragraph 1 (f), you say that the present arrangements concerning retirement should be retained but that people should be able to retire earlier where they themselves consider it desirable, without foregoing all their pension rights. That is ambiguous, is it not? Do you mean without foregoing the total of their pension rights?—Yes, it should really be the total.

83. *Chairman*: Do you really mean without foregoing any?—Any of the pension rights. Clearly, they should retain their pension rights.

84. Your point is that if people retire earlier they should not lose anything at all, rather than that they should not lose the whole lot?—*Dr. Joules*: They should be able to retire on a *pro rata* basis.

85. *Sir Hugh Watson*: They should not forfeit the whole lot?—No.

86. *Professor Jewkes*: Which, of course, they do not now, do they?—*Dr. Murray*: Unless you leave through

a breakdown in health, you forfeit your pension rights but not that part of the money which you yourself have paid into the fund. We are thinking more of the other side of it, which could be lost in its entirety, of course, at present. If you look at the ages of general practitioners, you will see that there are a very large number of them continuing in actual general practice until quite an advanced age; that is one factor. The other factor is that there are people who themselves are aware that they are not doing the job as they would like to do, and who would like to retire, but who have to hang on until they are 65 to get the pension.

87. You suggest, as it were, a firm retirement age of 65? What do you think are the disadvantages of allowing people to go on too long?—One of the main disadvantages, of course, is the question of blocking promotion for others: that is one of the disadvantages to the Service. There may be no disadvantage to the individual, and it may even be an advantage, quite apart from financial reasons, to go on beyond the age of 65.

88. What about the patient—is it regarded as a disadvantage to the patient?—*Dr. Joules*: I think it is extremely desirable that there should be at some stage an assessment of the professional capacity of an individual to continue, if he desires so to continue. Of course it is open to discussion at what age that assessment should take place. We have it within the hospital service at this age of 65, and I think it is extremely desirable that that should be retained, even though the upper age limit of continued service is raised.

89. *Mr. Bonham-Carter*: Is raised?—Yes, but at this stage I would say there is no argument for raising it until we have absorbed into the consultant ranks all those who are trained and waiting to get into those consultant ranks.

90. *Professor Jewkes*: You suggest there should be no raising of the age limit until the total number of registrars and senior medical officers has been absorbed. Does this mean that there is a shortage of consultants?—Yes, very definitely; and there is a mal-distribution of consultants. On the whole, the further north you go, the less per 100,000 of the population the consultant distribu-

tion is. There is a need, in our submission, for an immediate survey of this situation, which is reacting very seriously upon the provision of consultant services to the nation generally.

91. *Chairman*: Taking mal-distribution and shortage, would you say they both exist or only one?—Both.

92. Have you any idea how much?—I would not like to hazard a guess, because we have not done any special research: information was made available to the Ministry by working parties which surveyed every region. I believe that may be out of date, and I am sure that there should be an immediate review of this situation.—*Dr. Murray*: If you look at this question of distribution from the financial angle, we have one set of figures which are available and relate to the money spent by the consultant service per hospital bed. The figure varies from one region to another, as between £43 per bed and £68 per bed per annum, indicating a very big difference in the provision of services. The region which has the highest figures we do not accept as being over-doctored: it still has long waiting lists and still has long waiting times in its consultant departments.

93. *Professor Jewkes*: So that the case for more rapid promotion from Registrar to Consultant is not based so much on equity to the Registrars as an absolute shortage of consultants?—That is so.

94. *Chairman*: There is no shortage of candidates at the moment?—There is a shortage in some fields.

95. But in general?—*Dr. Joules*: In general medicine, surgery, obstetrics and gynaecology, there is a waiting list.

96. *Mr. Bonham-Carter*: Would the same sort of difficulties apply to the general practitioner service?—*Dr. Kerr*: All the evidence is that it is extremely difficult for would-be general practitioners to enter the profession. As soon as a vacancy is advertised, there are enormous application lists. The latest Ministry of Health report shows quite clearly how long some of the assistants have been waiting—some are still waiting to become established. The figures show there is a small nucleus of assistants in general practice who have been assistants since the inception of the Health Service. There is no doubt at all that if there was a better distribution of general practitioners throughout the

country and if there were better opportunities to establish general practices there would still be large numbers of applicants waiting to fill the vacancies.—*Dr. Murray*: There is the total given in the Ministry's report showing the number of applicants for each vacancy. It varies in different parts of the country and with different practices but, taking 2,000 to 2,500 practices, the lowest number of applicants for a vacancy was 30 and the highest number was over 100—that was for the larger practices. The lowest number for any practice, among the smaller ones, was 10.

97. *Sir David Hughes Parry*: You say on page 6 of your memorandum under recommendation "d" that the employment of general medical practitioner assistants should be discontinued and that they, with other general medical practitioners with numbers on their lists below 2,500, will take over the excess patients shed by those with above 2,500. Would you give us your reason for doing away with the assistants?—I think this is a phrase which we could have worded rather more clearly. What we are concerned with is the arrangement whereby a man can become an assistant and he paid any sum of money by his principal without reference to any particular scale, without reference to the amount of work he does, and without reference to what is happening inside that practice. In other words, he may be exploited under the present arrangements. We visualise that in a health centre service there would be the junior members of the health centre team in a sense acting as trainees to the more senior people; but their terms and conditions of service would be those fixed for the health centre. They would not be exploited as assistants. It is in that sense that we have used the word "assistants" here.

98. Would you explain what you really mean by exploitation?—*Dr. Kerr*: Exploitation consists of the employing doctor deriving extra money from the work of his assistant without benefiting the assistant proportionately. This may be a facile definition and one that I am sure could be picked to pieces, but it does happen. I take the view, in a professional and ethical sense, that once a man joins the ranks of a profession it is ethically wrong for him to serve another man, to work very much harder, work many more hours, and accept much

greater responsibility than his employer, while the additional benefits which accrue to the practice from his hard work are not passed on to him.

99. *Sir Hugh Watson*: What do you mean by "working many more hours"?—The assistant commonly works very many more hours than the principal. He is often saddled with too large a share of the calls. Many assistants find themselves doing a disproportionate amount of night work, when the principal, in fact, refuses to get out of bed for an emergency call. I regard this as a negation of normal professional relationships, and on ethical grounds alone it is something to be frowned upon and, if possible, stopped.

100. *Chairman*: Have you any figures to show how widespread this exploitation is, to which you have referred?—I am afraid, with great respect, that I must point out the immense difficulty of having a statistical analysis of this sort prepared. Assistants do speak of this, but the more timid ones who have a job at stake do not voice their opinions, except in private.

101. *Sir Hugh Watson*: You cannot give us any specific examples?—No, I cannot quote any figures.—*Dr. Murray*: There is a running commentary in letters to the medical Press from assistants, complaining about this sort of thing and it goes on the whole time. There are, of course, 1,500 assistants on this paid basis, and out of them there are always a certain number who write to the Press and raise the point. It is very much discussed in medical circles.

102. *Sir David Hughes Parry*: Do you think the assistant does not appreciate that he is getting a good deal of experience without perhaps the fullest degree of responsibility, and that he is also enjoying a measure of security?—*Dr. Kerr*: As regards your second point, Sir David, the very essence of the position of the assistant today is his insecurity. There are 10 men waiting to step into his shoes. That may not be so true of women as of men, of course.

103. He is more secure than he would be if he put up his plate and had his own practice?—I could not answer that question with a plain yes or no. There are plenty of examples of single-handed doctors putting up their plates and doing very well indeed. I can think

of cases where, within three years of putting up his plate a doctor has acquired his own assistant. There is scope in the under-doctored areas, but for various reasons many doctors prefer to remain in more pleasant and salubrious areas—and with this preference goes a degree of insecurity. As far as experience is concerned, I would submit this is rather an immeasurable quantity. I am not sure quite how much of the assistant's salary should be computed in terms of this nebulous conception of experience. I would not submit that an assistant must necessarily earn a salary on a level with his principal. That would be manifestly inequitable. But I think, if there are going to be assistants, we must ensure that they are less insecure than they are at the moment, also that their entry into practice is ensured and that their salary levels are governed by a standard instead of being left to a purely person to person system as they are at the moment. I know that evidence on these points is being supplied by another organisation. I think it would perhaps not be proper of me to express any more of what is perhaps beginning to amount to a personal opinion: but that is what we are thinking.

104. *Mrs. Baxter*: Have you any evidence as to how far this difficulty of the assistants is due to a purely post-war situation, rather than to something inherent in the system or anything to do with the National Health Service?—*Dr. Murray*: It has always been a point of criticism in the profession. I would say—I do not know whether *Dr. Joules* would agree—but I would say it is less today than it was at one time. Is that not so?—*Dr. Joules*: Yes.—*Dr. Murray*: It is a point which we have discussed very much before the war.

105. But it is not directly related to a sudden increase, a post-war increase, of recruitment to the medical profession?—*Dr. Joules*: No. I would agree with *Dr. Murray's* impression that this is a lesser phenomenon now than it was pre-war.—*Dr. Murray*: I think the existence of the trainee assistant, whose terms are laid down, and of whom there are a smaller number has modified the position as regards permanent assistants to some extent.

106. *Chairman*: I appreciate that. On your page 4, you make a specific

recommendation that the present salary scales of house officers are inadequate and should be raised immediately by at least 50 per cent.—Yes.

107. Is that 50 per cent. on what they are now getting, excluding the interim adjustments? Has that any consequential effect on any other points? Does it take into account, for instance, the amount that is allowed for board and lodging of house staff?—We were talking about gross incomes, as at present fixed, and gross includes board and lodging. Whether, if the gross was raised, the board and lodging would then be put up to reduce it, no one can tell.

108. There is an element of subsidy in the board and lodging allowance?—Some house officers say they could get far better for the money elsewhere.

109. Is that really so?—That is really so. Near strikes because the food is so bad have happened in a number of hospitals recently. When you have bedrooms of a very low standard, even bedrooms shared, then house officers do say they could do better for the money elsewhere. That is obviously a very debatable point, but we are talking about gross, and we put this recommendation in our memorandum because we felt that the position of the house officer is appalling, particularly when you remember that some of these officers are married men.—*Dr. Joules*: I think it is essential to remember that house officers do not live in at their own request. They live in because they are expected to be on duty usually at least five days a week and 24 hours a day. While there is an element of subsidy in the amount charged, there is a gross element of under-payment in the salaries which are at present allocated to them. Even if the hours of work they actually put in are calculated, I have heard some of them say that their pay would not equal that of an unskilled labourer.

110. And this relates just to the grade called house officer—it does not apply to the grade called senior house officer, which is rather a different thing, I gather?—*Dr. Murray*: Yes. We thought that if we made a start on house officers, other changes would have to follow, but not of this proportion.

111. Now that brings me back to our terms of reference. You have not given us any other lead as to what you think

remuneration generally in the Service should be, because you said you were not able to give precise figures. I take it this 50 per cent. for house officers is not the whole change you want? Broadly speaking, would you prefer to see remuneration brought closer together or spread further? Would you consider the distribution is about right or is it quite wrong?—We would prefer a total change in the sense, as we have indicated, of a longer incremental scale, with a top figure which was not necessarily as high as it is today. We have not in fact made serious calculations about Spens and 24 per cent. We are all involved in this and so we dare not say too low a figure. From the general point of view, we want to see a scale which will be high enough to ensure that the medical profession and the National Health Service gets its proportion of the people who can train to be qualified. We are well aware of the position with regard to other scientists in the health service. We know we have to take our place with other staff, the technologists, and so on, but we would like to see the ladder going up to a point which is high enough to attract a sufficient number to give the Health Service the quality it needs. We would like that ladder to give a better range to a larger number of people than it does at present.

112. *Mr. Bonham-Carter*: You say "high enough to attract". You are still prepared to see your very top coming down?—I do not think the absolute top need be as high. I am talking now of the top basic salary, plus merit award and including some proportion for domiciliary service.

113. *Chairman*: I have understood, as regards the general practitioners, that with a reduction in the lists to which you have referred elsewhere you envisage that some of those with very large lists would also come down under the new system and that a doctor with a small list would be more secure?—*Dr. Joules*: I am not sure that the Association generally would agree with that off-the-cuff statement made by Dr. Murray that the upper limit is too high, until we could have the advantage of the knowledge that you are trying to gain in respect of other professions. I think you would agree, Sir, it is extremely desirable that the health service—and particularly the medical profession—shall attract men of such ability as will enhance what we

regard as the most precious national possession, that is the national health. Therefore, Sir, we trust that you will do nothing—and we will say nothing—which would tend to diminish the flow of some of the best brains of the country into the medical profession and keep them there, for your sake as well as our own.

114. Very obviously, that is a consideration at all levels. On page 5, paragraph 4 you suggest that the recruitment of medical students should be based on as wide a social catchment as possible. In fact, recruitment, is not too bad at the moment, is it?—*Dr. Kerr*: We were thinking in this sense rather of the catchment area of the recruitment. We are not entirely happy that everybody who would make a good doctor necessarily has an equal chance of becoming one, and we would like to see this chance given to a larger proportion of the available manpower throughout the population of the country.

115. Would you expect that to produce more people than at present?—Not necessarily, but we would expect it to produce applicants from a greater range and variety of backgrounds. With this developing social recruitment we would expect a much more profound initial understanding on the part of the doctor of the sort of problems that many of his patients have to face. Many doctors have to learn this at the start of their careers instead of being imbued with it by the nature of the community in which they have lived.

116. But as you do not expect this system to produce any more students and you are not expecting to get more in total, are you expecting that some others would be discouraged?—I expect there would be less from other classes, yes.

117. Why?—For the simple reason that the medical schools can only take a certain number and of that number we would expect and hope that a greater proportion of these students would come from homes that at present could not support the idea of children going into medicine because of the long training and the heavy cost.—*Dr. Murray*: We have, in a statement to the Press, objected to the Willink Committee figures as regards this matter. We do not think it is correct to say that there will not be a further need to increase the number of doctors to be trained.

Chairman: You are asking us to base our calculations on the basis that the Willink Committee was wrong?

118. *Professor Jewkes:* I think it would help the Royal Commission if we could have copies of the statement that has been made.—Certainly. We can let you have that and expand it.

119. *Sir David Hughes Parry:* Is there implied in your answer a criticism of the selection of candidates by the medical schools, or is it purely a question of numbers?—It is a question of those coming up to be selected. At the moment there are people who might very well make good doctors and who, because they cannot get the grant which we are suggesting, do not even come up for selection.

120. *Mr. McIntosh:* Are the grants inadequate?—They are both inadequate and insufficient in numbers. People do not apply for them because they think there will be difficulty in getting them, so they go off into something else which does not require grants.

121. *Sir David Hughes Parry:* I was under the impression that every person accepted at a medical school does, depending on the income of the parents, get a grant such as a local authority's grant or a medical grant. Is that not so?—Yes, they can; but they are not adequate. They come after the event. We would like it to be much more clear that grants are possible for everyone in all sections.—*Dr. Kerr:* There are serious difficulties that come to our notice from time to time. I know myself a young man of considerable ability whose mother has lived apart from his father for a long time and has supported him. He is anxious to take up medicine but because she has already had this responsibility for a long time he will not envisage a situation where perhaps for some time to come his grant would be only for his course, and she would be saddled with the other expenses. It is this kind of thing that prevents people of this type—and a very fine type it is—from going into medicine. He will not even look at it.

122. Has he had a grant for training in another profession?—No. He is at this moment finishing at his grammar school, where he went on a scholarship, and he is being sustained in that. But the sort of problems that hit a household

of this sort where there is no wage-earning capacity up to the age of 25 are not solved by the government or local authority grant, which in general is insufficient to cover the five or six years' training.

123. But do you think that the medical profession is any different from, say, the legal profession?—*Dr. Joules:* The course is much longer, Sir.

124. *Sir David Hughes Parry:* Is it? If you want to become a solicitor it takes six years?—Yes, I would agree.

125. *Chairman:* I think we have gone as far as we can into that. I appreciate that you cannot be precise in these matters; but there is an element of imprecision about all this. I have just one more point: you have earlier mentioned your suggestion for keeping matters under review, and a relationship to the cost of living. Have you any special methods in mind of keeping under review the different ages, types and degrees, as it were, within the profession—because that is not quite the same thing and might be an important matter?—*Dr. Murray:* Up until recently we should simply have said that ought to be the sort of thing that should go to the Whitley Council.

126. You are simply affected in that by a single recent incident, are you?—Yes. Otherwise we would think that, if that machinery operated as we think it should, it could take up the sort of points you have mentioned.

127. *Mr. Gunlake:* There is a reference on page 7 of the document to an occupational health service. Can you in the barest outline, tell us what that is?—An outline is very difficult to give. We have in this country practically no industrial health service. We have a factory health service, which has a particular function in relation to accidents in factories, which sets up certain standards and that sort of thing. We have in some industries a medical service within the factory for accidents and other things, but out of a quarter of a million factories only something like 6,000 or 7,000 actually have a health service within the factory. We believe that one of the things we need in Britain is an occupational health service. We have used the word "occupational" rather than "industrial" so that we can cover accidents occurring in offices and so on as well as in industry. We think that the

next step for the National Health Service is to introduce such an occupational health service; and again we think that the general practitioner will have a part to play in this. We think that it could probably be to some extent related to the organisation run from the health centres; and it would absorb quite an amount of medical manpower.

128. *Chairman*: Would that therefore mean that there would be more medical manpower used in total?—*Dr. Joules*: Yes, Sir. I would just like to add to that that this country is suffering at present from an enormous load of ill health due to the first industrial revolution. We have never recovered from that, from a health point of view. We are now going into a second industrial revolution and I believe, looking at the lessons learned

from the first one, that it is essential that the risks to health should be fully safeguarded by an effective occupational health service which should not only tidy up the past but should look to the future. We must have doctors equipped to deal with these problems. I personally do not think that the Willink Committee pays sufficiently sympathetic attention to these needs.

129. I think we now understand what an occupational health service is, and we did not know before. Thank you very much.—*Dr. Murray*: Again, we will, when sending you our statement on the other aspects of the Willink Report, give you a little more detail on this point at the same time.

Chairman: Thank you very much, gentlemen.

(The Witnesses withdrew.)

Memorandum submitted by the Whole-Time Consultants' Association

INTRODUCTION

1. The Whole-Time Consultants' Association is the only professional body exclusively representing the whole-time consultant and specialist staff of the National Health Service Hospitals. Evidence is submitted to the Royal Commission on Medical Remuneration under the following headings:—

General Considerations	(paragraphs 2-11)
Professional Expenses	(paragraphs 12-16)
Domiciliary Consultation Fees	(paragraphs 17-19)
Senior Hospital Medical Officers	(paragraph 20)
Summary	(paragraph 21)
Appendix I: Memorandum submitted by Association of Whole-Time Salaried Specialists (Whole-Time Consultants' Association) to the Royal Commission on the Income Tax.	

GENERAL CONSIDERATIONS

2. Under the present terms and conditions of service the disparity between the financial inducement offered to part-time and whole-time consultants has an important and damaging effect upon the hospital service. Evidence on this disparity was considered by the Guillebaud Committee (¹) (paras. 398-400) and we would draw attention to the opinion expressed by that Committee (para. 404). "We are also of opinion that it is undesirable that the financial arrangements relating to the consultant service should be such as to provide a financial inducement to a consultant to apply for a part-time rather than a whole-time appointment".

3. In the view of this Association, there is a place in the hospitals for both types of consultant, whole-time and part-time. At present an important part of the consultant work of the country is done by the former. Figures for England and Wales at 30th June 1955 showed that 32% of consultants held whole-time contracts, whereas the comparative figure for Scotland at 31st December 1954 was 45%. Taken on a sessional basis, it would appear that in England and Wales nearly 42% of the overall consultant work was being done by whole-time consultants. The corresponding percentage for Scotland with its stronger tradition of whole-time consultant service was greater (¹, para. 402). We would not seek to make invidious distinctions between the value of the service rendered by each,

indeed we subscribe to the view that the amount of work done by a consultant, whether whole- or part-time, depends more upon personal factors than upon the type of contract.

4. It is our contention that the marked difference in income between the two types of consultant is having important disadvantageous effects upon the hospital service. Whole-time consultants frequently exercise their option to change to part-time contracts. The public, ever apt to equate merit with financial success, is coming to regard the whole-time consultant as being in some respects the professional inferior of his part-time colleague. (This misconception is strengthened by the tendency of many a whole-timer to become part-time when he achieves distinction.)

5. On first appointment the choice of whole- or part-time is often a matter of personal preference: to some freedom from the embarrassment of charging fees determines the choice, others specialise in a field in which private-practice earnings are naturally small (paediatrics might be instanced as an example), others again use equipment that is now too complex and too expensive to form part of one man's private professional equipment (radiotherapy for example), many see opportunities for research in whole-time work; mixed motives must operate in most cases. Whatever the reasons that determine the choice in the individual case this Association believes that there is an important advantage to hospital *morale* in seeking to retain a proportion of the highest paid of the medical staff in a whole-time capacity. The professional energies of consultants whose income is derived solely from salary are demonstrably entirely directed to the hospitals they serve. The nature of those services and, by implication, the value of the example thus set to the hospital as a whole was well set out in an article in the *Lancet* some years ago (²).

6. There is a number of whole-time consultant appointments where clinical work is linked with medical administrative duties. Consultants in this category have been denied the option to change to maximum part-time duties. The Bradbeer Report on the Internal Administration of Hospitals (³) has deplored the lack of inducement to attract experienced medical men to these posts in sanatoria, infectious disease hospitals and mental hospitals (paras. 118 and 143). In referring to large general hospitals the Report states "it will become impossible to find first-class men willing to take on the considerable burden involved if there is to be any risk of financial loss" (para. 72).

7. We welcome and would cherish the discretionary powers at present vested in Regional Boards to permit free change of contract from whole-time to part-time at the request of an individual consultant; we would not seek to fetter this freedom in any way. But we are aware that the need to make provision for his family and the financial advantages of a part-time appointment form the crux of the reason for the change in the case of those of our members who resign from this Association on changing to part-time contracts. Moreover, this Association knows of cases amongst its members where the change from whole-time even to maximum part-time could not be made without some loss in the efficient discharge of hospital duties that fill (and often more than fill) the working week. We know of some consultants who would have to cease to visit outlying hospitals were they to change from whole-time contracts and we recognise that such outlying hospitals would often fail to attract another part-time consultant for, say, 1½ sessions per week.

8. The widespread employment of whole-time specialists of consultant rank is a relatively new development. It is arguable that this is the natural consequence of the increasing complexity and cost of medicine, and that it was foreshadowed by the steady increase of full-time professorial units established in teaching hospitals throughout the English-speaking world in recent decades. During the past ten years this development has reached the stage at which the *Lancet* (⁴) could state in January this year: "Some non-teaching hospitals with whole-time staff are now winning a higher reputation for research and quality of service (which go hand-in-hand) than the older teaching centres". In parallel with this development there has been a steady decline in the value of money profoundly affecting all those with fixed incomes; but, as the purchasing power of the whole-time specialist's salary declines, the prospects of private consulting practice seem to improve. In the past few years there has been an unprecedented increase in the number of contributors to personal health insurance schemes by means of which individuals and whole families may insure themselves against the costs of private medical care in the event of serious illness. To-day many whole-time consultants face the choice

between, on the one hand, taking what they believe to be the retrograde step of changing to part-time contracts and, on the other, of continuing under their chosen conditions of work at a considerable and increasing financial disadvantage. The action the Government takes on the recommendations of the Royal Commission on Medical Remuneration will determine the choice and so may foster or cut short this new development of full-time consulting specialists in the vanguard of the advance of medicine.

9. If arguments such as those above have weight with the Royal Commission and if the Commission agree with the Whole-Time Consultants' Association that there is a place for whole-time consultants in the hospitals of the country, and furthermore, that these consultants are the professional equals of their part-time colleagues, then to maintain the present part-time/whole-time ratio (or something like it, and we would suggest no change) it will be necessary to remove the present financial deterrents to whole-time consultant service and so maintain recruitment and halt the present drift from whole-time to part-time practice.

10. We have had presented to us the argument that there should be a slight financial advantage in whole-time service, particularly at times of rising living costs and high taxation. The proponents of this view claim that the part-time man by virtue of his freedom to alter fees can alter the privately earned part of his income to match the changing value of money. This may be so but this Association considers that any financial discrepancy in favour of whole-time service is unnecessary for we think that to the doctor primarily interested in the practice of medicine (in this spirit we believe most medical students begin their careers) the freedom from preoccupation with the minutiae of fee-calculation will remain, as it is now, an attractive advantage of whole-time practice.

11. It is clear that the second Spens Report^(*) envisaged equality of financial inducement between whole-time and part-time. The cause of the present disparity lies largely in the advantages the part-time consultant often enjoys in the assessment of his income tax liabilities. These advantages are denied his whole-time colleagues at present and until such time as the recommendations of the Royal Commission on Income Tax^(*) become law. There is also an invidious distinction drawn between the two types of consultant regarding domiciliary visiting fees (para. 18-20 below).

PROFESSIONAL EXPENSES

12. In negotiation this Association has been quite unsuccessful in securing acknowledgment from the Ministry of Health that there are expenses necessarily and reasonably incurred in the course of a whole-time consultant's work which are not met by expense allowances from the Regional Boards. Without this support from the employing authority the whole-time consultant can claim no remission of income tax in respect of these expenses.

13. On the question of "a number of items of expense which must be met if the specialist is to perform his duties efficiently" the Spens Report (*op. cit.* para. 16) reads: "These include car expenses, expenses of travel apart from the use of a car; the cost of renewal of instruments and other equipment; the cost of books and journals, preparation of scientific papers, and subscriptions to professional societies; printing, stationery, postage, and telephone costs; and expenses of attendance at national and international professional meetings; and the expense of visiting hospitals and clinics at home and abroad, and entertaining visiting colleagues". Of these only a proportion of the car expenses and the cost of some instruments can be met from Regional Board funds. The whole-time consultant meets the others, and in some cases a considerable part of his motoring expenses also, out of his own pocket and bears full income-tax and sur-tax on this expenditure. On motoring expenses alone we have evidence that some of our members who travel far in the course of their work may subsidise the National Health Service by £100 or more for by this amount the official mileage allowance falls short of necessary professional motoring costs. The progressive reduction of mileage allowance with increasing professional annual mileage is a severe impost penalising particularly those who use their cars most in the course of their work. The Council of this Association has had difficulty in restraining a group of its members who would seek to withhold the use of their cars for Health Service purposes and, by depending solely upon public transport, force a break-down of their part of the hospital service and so draw public attention to this grievance.

14. In the matter of post-graduate study expenses the whole-time consultant is at a grave disadvantage and the quality of his work must suffer in consequence. We are affected by the principle that "study leave with expenses" will only be granted to those who contribute papers to the meetings they attend. The part-time consultant who attends to learn rather than to teach can reclaim some of the cost against tax as a professional expense, his full-time colleague is unable to do this. In recent years as the value of money falls whole-time consultants have necessarily made their economies by cutting down just that expenditure which must be incurred if they are to keep abreast of their subjects and efficient in their work.

15. We recognise that professional expenses vary so much between individuals that additions to salary on this account might lead to extravagance with public funds. The matter may best be decided in individual cases by income tax reliefs in the usual way of professional expenses of this sort. Here we would reiterate that repeated attempts through the official Whitley machinery have failed to secure the admission by the Ministry of Health that there are such expenses. Without such an official endorsement we have been unable to influence the Treasury and so the Inland Revenue authorities on behalf of the whole-time consultants and their necessary and reasonable professional expenses. The Spens Committee "presumed that the Inland Revenue authorities would be prepared to consider favourably as legitimate allowances for Income Tax purposes any items of expense which had been approved by a public hospital authority" (para. 16). In the case of the whole-time consultant this premise has proved largely false; insurance against medical litigation (£2 0s. 0d. p.a.), a condition of employment, is the only professional expense that has this approval.

16. Oral and written evidence was given by this Association (Appendix I) before the Royal Commission on Taxation (*). That Commission has recommended that schedule D and E incomes should be equally generously treated in respect of expense-relief. That recommendation has yet to become law.

DOMICILIARY CONSULTATIONS

17. In the matter of Domiciliary Consultation Fees the whole-time consultant is treated with disadvantageous financial discrimination. The part-time consultant is permitted a maximum earning of £840 (200 visits) *per annum* under this heading, he has the right to charge private fees in respect of visits made in a private capacity. The whole-time consultant must make eight visits without fee per quarter before he becomes eligible for any fees to the £840 maximum. We understand that thirty-two visits is the national yearly average for all types of consultants. Certain operative procedures may be undertaken in the course of a domiciliary consultation visit, but the operation-fee (together with the consultation fee) is withheld from the whole-time consultant for the first eight visits of each quarter.

18. The Spens Committee (†) clearly makes no differentiation between part-time and whole-time consultants in its recommendation (para. 7) that "because of the very considerable additional burden which such domiciliary visits involve we consider that some additional remuneration should accrue in respect of these". Within a few months of the inception of the National Health Service the Domiciliary Consultation Fee was withdrawn from whole-time consultants with the result that domiciliary visiting by whole-timers virtually ceased and many patients who might have been cared for at home were sent unnecessarily into hospital. Even now the obligatory eight "free" visits each quarter deters general practitioners from calling out their whole-time consultant colleagues.

19. The country-wide availability of consultant opinion in the patient's own home regardless of the patient's means represents one of the major achievements of the National Health Service. It seems unfortunate that this achievement should continue to be marred by the reluctance of general practitioners to seem to impose upon their whole-time consultant colleagues and by a sense of grievance at unfair discrimination harboured by some whole-time consultants.

THE SENIOR HOSPITAL MEDICAL OFFICER

20. The Whole-Time Consultants' Association is also concerned with the professional well-being of those specialists at present graded Senior Hospital Medical Officer. In England and Wales at 31st December 1955, 55% = 1,240 of the Senior Hospital Medical

Officers were whole-time. We recognise that there is a need in the hospital service for a post intermediate between Senior Registrar and Consultant; we believe that what has been described as the "dead-end" nature of the Senior Hospital Medical Officer grade has brought it into disrepute. We draw the attention of the Royal Commission to the need to facilitate promotion of Senior Hospital Medical Officer grade specialists to consultant rank and to avoid the false economy of the appointment of a Senior Hospital Medical Officer specialist where the services of a consultant are required. For the good of the hospital service of the country we believe that the salary scale of this grade should be sufficiently generous to ensure adequate life-earnings and pensions to those whose careers will end in this grade. We also believe that those Senior Hospital Medical Officer specialists who undertake domiciliary consultation visits should be eligible to receive fees for all domiciliary consultations.

SUMMARY

21. Evidence is given of the part played by whole-time consultants in the hospital work of the country. Both in the discharge of their day-to-day duties and in their contribution to the advance of medicine, the whole-time consultants represent a relatively new, but important national asset. The present terms and conditions of service impose financial discrimination against this group of doctors, particularly in regard to income tax allowances for professional expenses and in the matter of domiciliary consultation fees. The economic plight of specialists in the Senior Hospital Medical Officer grade is also stressed.

The present financial rewards of part-time as against whole-time consulting practice are such that there is a danger that no one free to change his contract will continue in full-time work. Should this threat materialise, one of the most promising developments fostered by the National Health Service will have failed.

REFERENCES

- (1). Report of the Committee of Enquiry into the Cost of the National Health Service. Cmd. 9663.
- (2). "The Full-Time Specialist". F. Avery Jones, *Lancet* 1948, 1, 6499.
- (3). Report on the Internal Administration of Hospitals. Ministry of Health 1954.
- (4). "The Support of Medical Research". *Lancet* 1957, January 12th, pages 83 and 84.
- (5). Report of the Interdepartmental Committee on the Remuneration of Consultants and Specialists. Cmd. 7420.
- (6). Report of Royal Commission on Taxation of Profits and Income. Cmd. 9474, June 1957.

APPENDIX

MEMORANDUM SUBMITTED TO THE ROYAL COMMISSION ON THE INCOME TAX BY THE ASSOCIATION OF WHOLE-TIME SALARIED SPECIALISTS, 45 LINCOLN'S INN FIELDS, LONDON, W.C.2

1. The members of the Association hold whole-time appointments as medical specialists in the National Health Service. As the law stands, they are charged with Income Tax under Schedule E and are denied relief in respect of incidental professional expenses which would be allowed, without question, if the charge were made under Schedule D. The Association believes the right principle to be that reasonable and necessary professional expenses should in all cases be allowed as a deduction in arriving at the liability to tax upon the earnings from the profession. The Association hopes that the Royal Commission will consider and recommend an appropriate change in the law.

2. The Association feels entitled in the interests of its members to emphasise their special circumstances as members of the medical profession with an overriding duty to their patients. At the same time, the Association appreciates that any change in the

law would have to apply to all holders of offices and employments so long as such persons remain chargeable with tax under distinct rules. The Association observes, however, that the rigidity and narrowness of the existing Rule 9 of Schedule E have attracted criticism in the Courts, and considers that an appropriate alteration in the law is overdue.

3. The Association desires to submit to the Royal Commission that the law and practice under Schedule E should at least be brought into closer alignment with the law and practice under Schedule D. The Association has noticed in this connection that the Committee on the Taxation of Trading Profits (Cmd. 8189, 1951), presided over by Mr. J. Millard Tucker, K.C., has proposed that a clear right should be given to a deduction under Schedule D for involuntary outgoings due to events incidental to and occurring in the course of carrying on a business. The expenses which fall upon the members of the Association in the course of carrying on their profession may in the strict legal sense be expenses which they incur voluntarily. The expenses are however in a wider sense unavoidably incurred by them in carrying out their professional work.

4. The fact that whole-time specialists, in common with part-time specialists in the National Health Service, and with other members of the medical profession in this country and abroad, need to incur certain types of expenses in carrying on their profession was recognised by the Inter-Departmental Committee on the Remuneration of Consultants and Specialists, presided over by Sir Will Spens, C.B.E. An extract from the Committee's report (Cmd. 7420, 1948) forms Appendix A to this memorandum.

5. Attached as Appendix B to the memorandum is a copy of the terms and conditions of service of hospital and medical staffs in the National Health Service (England and Wales). Paragraph 19 of this document governs the payment of expenses to the members of the Association. The result broadly is that the expenses of travelling are met by the authorities (by means of a scale in the case of car expenses), and that other expenses may be claimed where directly related to the performance of the duties under the particular authority or authorities.

6. So far as official regulations go, and their application can said to be standardised, it may be suggested that the Association's members are not bound to incur any expenses out of their emoluments. The true position is that expenses are unavoidably incurred in carrying out their work as was envisaged by the Spens Committee. It is in fact essential to the proper functioning of the National Health Service that whole-time specialists should in the fullest sense continue to be practising members of the medical profession, and engaged with their colleagues in the advancement of medical knowledge and skill by means of practice, study and research. In the view of the Association, it is unreasonable that its members should not be given relief from tax on expenses which they incur with that object as part of the performance of their duties.

7. A deduction is refused under present law for any expense that is brought within the principle laid down by the late Mr. Justice Rowlatt in his judgement on the case of *Simpson v. Tate*. An extract from the judgement is given as Appendix C to this memorandum. The Association suggests to the Royal Commission with confidence that the principle as laid down in that judgement, if it were to govern the conduct and expenditure of members of the medical profession holding full-time appointments in the course of their careers, would have the poorest results both to the public service and to their patients.

8. Grounds on which the members of the Association are in practice refused deductions for professional expenses are that expenditure within the narrow scope of Rule 9 of Schedule E is met or may be claimed under the regulations, and, if neither met nor claimed, is expenditure voluntarily incurred for purposes going beyond the duties that are required to be performed.

9. The main grounds on which any change in the law has in the past been resisted are that the holder of an office or employment performs particular duties within a definite area for a fixed remuneration, and that any weakening of the present Rule 9 of Schedule E would let in claims by such persons for all kinds of voluntary expenditure. The Association nevertheless suggests that the rigidity and narrowness of the Rule impose hardship at present rates of tax, both actually and relatively to Schedule D, which the Royal Commission endeavour to remove.

10. Amounts of expense in which the members of the Association are involved year by year, while not in general large, are not inconsiderable and may in some circumstances be substantial. Most or all of the members have expenses under such heads as follows:—

- (a) Subscriptions to specialist medical societies whose object is the advancement of medical knowledge and skill.
- (b) Expense of attendance at meetings of, or conferences arranged by, such societies.
- (c) Costs of maintaining a suitable personal library, and costs of medical periodicals.
- (d) Replacement in some circumstances of instruments and appliances.
- (e) Telephone expenses at the place of residence, and, in special cases, other expenses there such as the maintenance of a study.

11. The Association believes that Inspectors of Taxes, and in case of disagreement, the Commissioners of Taxes on appeal, would be able to decide upon cases according to their particular facts, if deductions for expenses of the kinds in question were permitted under proper safeguards.

12. To avoid possible misunderstanding, the Association wishes to say that it is no part of this memorandum that a deduction should be given for subscriptions to medical bodies which are or are comparable with trade unions, or for subscriptions or other expenses incurred for the purpose of obtaining additional professional qualifications at any stage of a career.

13. The Association adds that it is aware of a practice of allowing a deduction under Schedule E for subscriptions to professional societies, where the employer requires membership to be maintained as a condition of the employment. This practice has no present bearing on the subscriptions which are the subject of the Association's representations. Membership of the main medical bodies in question is attained by individuals who already possess the necessary high qualifications and who are elected as members.

14. The Association would like to mention as a final point that the expense of running and maintaining a car for professional purposes may exceed the payments received on the official scale. Claims by members to relief from tax (including claims for initial and wear and tear allowances) are refused. The grounds, put baldly, are that authority has determined in advance what expense will be necessary, and the actual costs of running expenses, service charges, repairs, etc., are irrelevant. The refusal can give rise to hardship especially in present conditions of limited choice of car, and is apparently wholly out of line with the practice obtaining under Schedule D. The Association would like to see the law altered, if this is what is necessary to remove the differentiation.

P.S.

Submitted to the Royal Commission on behalf of the Council of the Association by:—

RUFUS C. THOMAS,

F.R.C.S.E., F.R.C.O.G.

President.

C. ALLAN BIRCH,

M.D., F.R.C.P.

Hon. Secretary.

November, 1951.

APPENDIX A

TO THE MEMORANDUM SUBMITTED BY THE ASSOCIATION
OF WHOLE-TIME SALARIED SPECIALISTS

Extract from the Report of the Inter-Departmental Committee
presided over by Sir Will Spens, C.B.E.

"There are three further points to which we wish to refer in order to avoid any possibility of misunderstanding.

"Firstly, throughout our proceedings we have assumed that specialists engaged either whole-time or part-time in a publicly organised service will be paid any sums which represent expenses necessarily and reasonably incurred in the course of their work, and that these sums will be in addition to the salaries recommended. The Evidence Committee has brought to our notice a number of items of expense which must be met if the specialist is to perform his duties efficiently. These include car expenses: expenses of travel apart from the use of a car: the cost of renewal of instruments and other equipment: the cost of books and journals, preparation of scientific papers, and subscriptions to professional societies: printing, stationery, postage and telephone costs: expenses of attendance at national and international professional meetings: and the expenses of visiting hospitals and clinics at home and abroad, and entertaining visiting colleagues.

"The expenses might be refunded after they have been incurred, or alternatively an appropriate allowance for expenses might be attached to the various posts held by specialists and consultants. If the latter course were adopted it would have to be realised that certain expenses would arise which had not been foreseen when the allowance was fixed, e.g., attendance at an international conference, and additional provision would have to be made in such cases.

"It is presumed that the Inland Revenue authorities would be prepared to consider favourably as legitimate allowances for Income Tax purposes any items of expense which had been approved by a public hospital authority."

(Extract from paragraph 16, on page 13 of the Report,
headed "Expenses, Superannuation and Holidays.")

APPENDIX C

TO THE MEMORANDUM SUBMITTED BY THE ASSOCIATION
OF WHOLE-TIME SALARIED SPECIALISTS

Extract from the Judgement in the High Court in the
Case of *Simpson v. Tate*

The respondent was medical officer to the Middlesex County Council. In giving judgement for the Revenue, the late Mr. Justice Rowlatt said:

"... The respondent qualified himself for his office before he was appointed to it, and he has very properly endeavoured to continue qualified by joining certain professional and scientific societies, so that by attending their meetings and procuring their publications he may keep abreast of the highest developments and knowledge... When one looks into the matter closely, however, one sees that these are not monies expended in the performance of his official duties. He does not incur these expenses in conducting professional enquiries or get the journals in order to read them to the patients..."

"I think it is desirable to lay down some principle applicable to cases of this kind. In my view the principle is that the holder of a public office is not entitled under this Rule to deduct any expenses which he incurs for the purpose of keeping himself fit for performing the duties of the office, such as subscriptions to professional societies, the cost of professional literature and other outgoings of that sort... The principle seems to be clear that no such deductions as these can be permitted."

Reported at (1925) 2 K.B. 214.

Examination of Witnesses

DR. C. ALLAN BIRCH

DR. A. A. CUNNINGHAM, *Secretary*

DR. L. T. HILLIARD

DR. R. M. MAYON-WHITE

on behalf of the Whole-Time Consultants' Association.

Called and Examined

130. *Chairman*: You are, gentlemen, very early on the list of witnesses to be here before us. I hope you will understand that we must try to press the various statements you have made in your written evidence particularly on facts, because unless we ask something, nobody else will. Therefore when we are questioning you I hope you will not feel there is any hostility or necessarily disbelief on our part. Equally, failure to pursue a point does not mean necessarily that we accept it or that we think it is irrelevant. Any Member of the Commission will have a chance to ask you questions and will probably do so, but for convenience we have given the task of sifting the many memoranda we have received to two separate sub-committees. Your very useful memorandum was submitted to a sub-committee of which Sir David Hughes Parry acted as chairman, so that he will be leading off with most of the main topics.

I think I ought also to add that a good deal of the information submitted by some organisations—and not particularly by you—goes some way outside our terms of reference. We are quite prepared to ask questions on these things in order to get the general picture as it affects remuneration, but of course we shall not be reporting on all the things we choose to question you upon. We may even choose to question you on things which are not in your memorandum, so as to get a full picture. I would perhaps just add that we understand well that the whole question of doctors' remuneration does not solely involve facts and figures. We are aware of these other sources of dissatisfaction to the profession but we will be primarily concentrating for the moment on facts.

I think it would be a good beginning if you would tell us a little bit about the membership of the Association today, not only in numbers but as regards the extent to which it covers the full

potentiality of the whole-time consultant.—*Dr. Birch*: We have more than 300 members, and that is between one-third and one-quarter of the number of whole-time consultants in the Service.

131. And is the reason for it being one-third to one-quarter, and not three-quarters or five-sixths, because you have very high entrance fees, or because people disagree with you, or because they are disinterested?—I do not think it is the fees, Sir. I think it involves various factors. We have noticed that our membership goes up when consultants feel we are doing something for them, when things are taken up which affect individual members.

132. I see. We have just been speaking to the Socialist Medical Association, and they have made it quite clear to us that their primary characteristic is their socialism. Your characteristic is . . . ?
—We really represent whole-time clinicians and hospital workers. There are very many people in the whole-time medical profession who are on university staffs, and so on, but they are not so strongly represented.

133. Is there a special reason for that? Do they disagree with you?—No, I do not think they disagree with us. It is just that they feel we cannot look after their interests so well as their own professional bodies.

134. I see. That does give us a little bit of the background.—*Dr. Hilliard*: Might I add a note to that? I think our Association is one which does not give any direct benefit to the members. It is not like some of the professional associations which give financial advantages. For example, the Association of Scientific Workers brings various direct benefits to their members in insurance and things like that; and agencies for finding jobs. We merely try to represent our members' interests, and not only the interests of our members but the interests of the

whole-time service, to make sure that the people who are working full-time in that service have reasonable conditions. Although we cannot say that we represent individually all the people concerned, I think we are a very fair representation of people who are bothering to spend time to try and negotiate for a good full-time service and, indirectly, the conditions of the people in it.

135. You represent the whole-time consultants—you do not include people of lower ranks?—We include SENIOR HOSPITAL MEDICAL OFFICERS, if they are of virtually consultant status. Our members are vetted by our Council, and we only accept people who are virtually whole-time specialists or consultants.

Chairman: Thank you very much. That covers the preliminary points.

136. *Sir David Hughes Parry:* You have seen the factual memorandum submitted by the Ministry of Health?—No, Sir.

Chairman: It is obtainable from the Stationery Office and it contains, I think, only facts.

137. *Sir David Hughes Parry:* I will read to you two passages on page 25 of the Ministry's factual memorandum on which I would like your help.

"Following discussions more recently between the Ministry of Health and the Department of Health for Scotland and the Joint Consultants Committee, the following statement was published in the 'British Medical Journal' and the 'Lancet' in 1955. The Joint Consultants Committee have had recent discussions with the Ministry of Health and the Department of Health for Scotland about whole-time and maximum part-time service for consultants in the National Health Service, and the following is an agreed statement of the position."

—*Dr. Cunningham:* We have this, yes.

138. What I would like to know is, would you agree that this implies really that the amount of service rendered by a full-time person and a person with maximum number of sessions is about the same?—*Dr. Mayon-White:* No, Sir, it is not the same. You say you have room in your considerations for intangibles. We think there is a very real difference between a man whose whole professional interests are devoted to the hospital he serves, and those who at

the same time nurse a growing private practice outside. In terms of the number of sessions, nominal half-days in a working week and so on, there is a difference between nine and a half elevenths and eleven elevenths. Many of us—I myself, for example—would have to give up one hospital if we changed to a maximum part-time contract. One of my hospitals and, travelling time takes up about a day and a half of my week. I think I should have to abandon that, if I surrendered my whole-time and elected to a maximum part-time contract. There are other ways I might economise on my working week. I might cut out some of the things I think are refinements in the service I give. But I think this Association does see the difference between the type of service we give whole-time, and that which we would give part-time. We do not think our part-time colleagues give less than their full service to the hospital, but we can say that in these intangibles we see some difference.

139. The agreed statement says: "In such a case the successful candidate should not be asked to state his preference until after he has been selected for appointment." That implied to me that there was not much difference.—May I point out the words that say in effect, that where the Board decides that the needs of the hospital service demand a whole-time appointment, competition should be thrown open to all applicants who are prepared to give substantially the whole of their time to the post. In my own case the Board, I think, would not appoint a part-time children's specialist. I have the option to change and perhaps I might get away with it, but I think the service would suffer if I were to revert to maximum part-time.—*Dr. Hillard:* Why else would there be any need to have this reservation that in certain circumstances the Board would elect for the whole-timer? That implies there must be situations where you do need the whole-timer.

140. But in the present set-up there is room for flexibility, which you would agree is a desirable thing?—Yes, Sir, but you see the hospital is a going concern. Perhaps the whole-timers are there all the time and carry a little extra burden which is not discussed, but the whole-timer is there to deal with situa-

tions that arise when his colleague is not there. I think those are imponderables that are very difficult to estimate. But personally, from the point of view of running a hospital I would prefer to have enough whole-timers to make sure it goes smoothly, than to have everybody part-time. If everybody is part-time there is something missing. There is nobody to turn to, and in that sense we do not feel they are really equal.

141. What you say is that in most instances or in many instances the whole-time service is essential but there are other cases where either would serve equally well?—It depends on the pressure of work. On the question of hours, the part-timer is travelling and is allowed a proportion of his service for travelling. The whole-timer is not. I would expect him to be there from 9 till 5, whereas the other person comes in so much travelling time later, so in hours he is not seeing so many patients. We do not want to stress that.

142. *Professor Jewkes*: Whole-timers can work in more than one hospital and in that sense spend time travelling. How common is it for the whole-timer to be working in more than one hospital?—It depends on the size of the hospital and the particular specialty he is working in. I would not like to generalise. Some do quite a lot of travelling and others do not.

143. *Chairman*: More than half the whole-timers work in one hospital?—*Dr. Cunningham*: Generally one main hospital I think, and one or two subsidiary hospitals. I myself work in three different hospitals. But I spend the great majority of my time in one hospital. I normally pay only occasional visits to the others. Most of the subsidiary units are within a very small radius of the main hospital.

144. May I ask if the four of you work in widely different parts of the country?—*Dr. Mayon-White* is in Ipswich, I am in S.W. London, *Dr. Birch* is in N.W. London and *Dr. Hilliard* is in Tooting.

145. *Professor Jewkes*: You make a quotation in paragraph 2 of your memorandum. The quotation is made from the report of the Guillebaud Committee and I wondered whether in your opinion there is in fact a financial inducement

to a consultant to apply for a part-time rather than a whole-time appointment? If you do think that, what do you think should be done about it?—*Dr. Birch*: I think that is a large part of what we are concerned about. We have not mentioned specific figures in our memorandum so much as the general principle. We feel that there is a financial inducement for a man to be part-time because of the various expenses and allowances and so on that he can obtain through the Income Tax Inspector from the fact of his being part-time, and also because his free sessions can be used in getting whatever private practice there is still to be got.—*Dr. Mayon-White*: I would make it clear that we did not give evidence to the Guillebaud Committee. We are not using our own quotation; it was an independent finding that there is this financial discrimination. We feel that too, and that explains our presence here this afternoon.

146. At least at this point the Guillebaud Committee does not commit itself to whether this is a fact or not. They simply say it would be undesirable if it were a fact. I am trying to get clear your opinion as to whether there is this financial inducement to move from part-time to whole-time work.—Yes, definitely.—*Dr. Cunningham*: I have detailed figures from my own region, that is the south-west Metropolitan region, which employs a total of 1,200 consultants. I think it is the largest region in the country and in that region there are actually 39 consultants who have changed from full-time to part-time over the last three to four years. Before that there was a negligible number of changes but during the last three or four years 39 consultants changed from whole-time to part-time. In the region as a whole, out of 270 whole-time consultants, there are 231 consultants left, after these 39 changed from whole-time to part-time service. Of the S.H.M.O.s four people have changed from full-time to part-time service, out of a total of 160 odd full-time S.H.M.O.s.

147. Has there been any movement from part-time to whole-time?—There have been five, and I have that under the various specialties; three in anaesthetics, one in pathology and one in radiology.

148. *Sir David Hughes Parry*: This is the aggregate and not merely your

membership?—This has nothing to do with our membership at all. This is from the Senior Administrative Officer of the South-West Metropolitan Regional Board.

149. *Chairman*: We have a list of specialties. The number of whole-timers varies considerably from specialty to specialty. Are there any specialties in which you would feel there is virtually no movement towards part-time?—*Dr. Birch*: Some have virtually no part-time work, such as radiotherapy where it is all done by full-time people.—*Dr. Hilliard*: And psychiatry, I think, has a larger proportion of whole-timers; it claims to be a full-time job to a greater extent than others.

150. *Sir David Hughes Parry*: What accounts for that?—The nature of the work.

Chairman: There are 76 whole-time consultants and 44 part-time ones in radiotherapy which is rather more than you would have guessed.

151. *Professor Jewkes*: Whilst we are trying to get this picture in our mind can you tell us anything about the degree to which purely private practice among consultants is increasing or decreasing?—*Dr. Mayon-White*: No, Sir, we have no private practice. Anything we might know about that would be just hearsay.

152. *Chairman*: There is no list of those who are whole-time private consultants; they are not on the lists at all?—*Dr. Hilliard*: The Ministry would not have access to them.—*Dr. Mayon-White*: You would have to ask other people who know from their own experience. We do know that people can now be insured for health purposes through a scheme. One pays a sum and gets private fees repaid if one's children go into hospital. We know that kind of personal health insurance is increasing very much. The reason is that it will very often secure private care in the event of sickness. We know that a lot of our part-time colleagues are deriving a great part of their private income from that source.

153. That would be mainly carried out by part-time people. Can you say whether the proportion of partnership of time is decreasing; that is to say, instead of giving eleven elevenths they are giving so many less elevenths? Is that going down, or is it on the whole remaining

pretty near the maximum of part-time?—*Dr. Hilliard*: These figures have been put in a report. We would not like to give evidence on something not our concern.

154. You wish only to deal with the full-time?—*Dr. Mayon-White*: But it is one's impression, as near the maximum part-time as you can get is the best position to be in financially.—*Dr. Birch*: This change from whole-time to part-time, Sir—we do not know the numbers of people who want to change but are not allowed to do so by their Board. We understand some Boards do not allow it.

155. *Sir David Hughes Parry*: I wonder if I may take you to paragraph 4 of your memorandum where you make three statements. I would like very much indeed to have some supporting evidence, if you could help us. The first sentence is: "It is our contention that the marked difference in income between the two types of consultant is having important disadvantageous effects upon the hospital service". Could you enlarge on that? It is a little wider than the matter we discussed before?—*Dr. Mayon-White*: We have dealt with the first one. We have given you the figures for the whole-timers exercising their option to change to part-time.

156. This is a little wider than that—"having important and disadvantageous effects upon the hospital service". There is implicit in what you say that the part-time is disadvantageous.—*Dr. Hilliard*: I think, Mr. Chairman, I mentioned earlier that from the point of view of running a hospital, if you have too many part-time staff there are difficulties inherent in the administration. These, I think, have a disadvantageous effect on the hospital as a hospital. Provided there are enough whole-timers to keep things going, I think it is all right having both but if there was a continued trend of more and more people going part-time those who are whole-time feel that the service would not be so effective.

157. That is the only point really you want to make on that?—Yes. It is in a sense altruistic. We are speaking of the effect on the service. If we all go part-time, we think we shall be better off, but we shall leave behind a hospital which has not the effective service to the public it has now.

158. Parallel with that, the organisation of the teaching departments at the teaching hospitals?—Yes.

159. *Sir Hugh Watson*: Would you have modified this statement in the light of what you have told us to the effect that if this swing to which you have referred continues, it could have important disadvantageous effects on the hospital service?—Yes. Perhaps we have exaggerated a little there but it is the tendency we are concerned about.

160. *Sir David Hughes Parry*: I do not know whether there is anything further you would like to say about the third sentence in that paragraph?—*Dr. Hilliard*: One tangible proof is the hospital car park. The larger cars are not the whole-timers' cars. Again, they are things difficult to prove, but all these things are linked up in the public mind and I think they get the impression that one doctor must be better than another if he has that kind of car. It is a joke in the hospital. The staff know that the smaller the car, the more likely the owner is to be full-time.

161. *Chairman*: I was not sure whether achieving distinction meant achieving an award.—As he becomes a more senior person to his colleagues, he feels it would be wiser to establish his position, to be a part-timer, and run his life that way to try and achieve the same distinction.—*Dr. Mayon-White*: The word was carefully chosen, Sir. If you get a grade C merit award, it probably cancels the difference between whole-time and maximum part-time salary, and it may cushion you against a drop in income.

162. In your meaning it did mean distinction award?—No, Sir. It means exactly what it says. As he goes up and becomes well-known, so also will he begin to attract a lucrative practice. We would feel, Sir, it is particularly that man at that time of his life whom is important to retain working whole-time within the hospital so everybody else realises his activities are devoted entirely to the hospital, and that he has no outside interest. We feel those men who leave us towards retiring age are some of our most useful members lost to this Association.

163. *Sir Hugh Watson*: A loss to the service?—A loss to the hospitals in

some sense, in that they now develop an interest outside.

164. *Professor Jewkes*: Or a loss to private practice?—No, Sir, a gain to private practice.

165. *Chairman*: You raised a separate point. You say, as they approach retiring age. In fact, cannot the part-timer continue doing his outside work up till a hundred, if necessary, and therefore has he not some advantage in carrying on a practice that does not end automatically at a specific age?—That may be so to some extent, Sir. I do not think we can tell you how much private practice earnings are influenced by it becoming known that a man has reached his hospital retiring age. There is a dwindling at that time.

166. He can go on in one place but not in another?—Yes, and he does so.

167. *Mrs. Baxter*: Your view is that the individual hospital does not suffer in any way from the fact that a man may be doing part-time work in one hospital, and another, and a third? His work in each will be equally valuable to that hospital? So am I right in thinking you would view the quality of attention which a man pays to a part-time private practice as in some way different from the quality of attention which he pays to his hospital service?—Yes, I think so.—*Dr. Birch*: If a man has a difficult case and he is a sessional man and his session comes to an end, he goes somewhere else; but we feel the whole-time consultant has the time at his disposal to devote as adequate an amount of time to a difficult patient as he would another. He has not the outside attractions to take him away from hospital service.—*Dr. Mayon-White*: May I give Mrs. Baxter a personal answer? In the evenings when I am signing my letters at about six o'clock in the hospital the parents are saying good night to their children; it is their habit to ask the Sister or the House Surgeon about the case. If they cannot get an adequate answer, they know I am in my room. Now I think that is part of my job, and I am in the hospital to do it. But I rather think if I were in part-time private work, at that time in the evening I ought to be at home to see private patients and I would not be late in the hospital. I should still be available to see parents

by arrangement, but there is a certain informality of approach one sees in whole-time work which one does not see, naturally enough, in a person who has an interest outside.

168. *Professor Jewkes*: Would you agree that in this, as in so many other matters, men differ?—Yes, Sir.

169. And there may be doctors who would be best as whole-time consultants and other doctors who would only give of their best if they were working on a part-time basis? One cannot envisage the kind of service which would suit everybody?—I would say here that we do not think that doctors work for what they can get out of it, shilling for shilling.—*Dr. Hilliard*: We do not want to generalise and speak of black or white, but we feel the service can benefit from some people doing the work on a full-time basis; and we think these people should have a proportionately equal remuneration to the others. We do not think today the full-timer gets the same recompense as his part-time colleague, *pro rata*.

170. *Mrs. Baxter*: And in fact your paragraph 9 suggests you think the part-time/whole-time ratio at the moment is pretty good if the other things were made equal?—Yes.—*Dr. Mayon-White*: Perhaps there one could say we do not yet quite know the effect of this freedom to choose part-time, because that has only come up recently. The present ratio very largely depends on appointments being made in terms of whole-time or part-time according to the needs of the service. You heard the figures of the turnover when freedom of choice was granted.

171. *Chairman*: You know of course that we are sending out questionnaires to many doctors and individuals, asking for details which should show up what you probably are not in a position to say, that is the real difference in earnings between people in approximately similar positions and capacities. Those who are part-time, those in different degrees of partness, and those who are the whole-time. But that is a question of fact.—*Dr. Hilliard*: We have not the facts of course. We only have this feeling, and we are speaking on behalf of the whole-timers.

172. *Sir David Hughes Parry*: Paragraph 5—you give paediatrics there as

an example. We thought that might refer to pathology rather than paediatrics, because we have figures that might suggest that.—I think paediatrics has the reputation of being one of the worst paid specialties. The reason is obvious. The people who are raising a young family and need a children's specialist have very heavy calls on their incomes; they have not very good incomes at that time, so they are not able to pay very large fees for a children's specialist. Therefore I think very often paediatricians tend to be whole-time. Pathologists, because of their equipment, which is so expensive, almost always nowadays are whole-time from the beginning.

173. *Chairman*: You realise that there are in fact four times as many part-time paediatricians as whole-time?—I do, Sir, yes. There has been a change. I am still whole-time but I am very tempted by the thought that private fees in paediatrics are now guaranteed by family insurance companies, and I think you will find there has been a big movement recently for that very reason.

174. This was June, 1956, this figure.—The freedom to change came in 1954 I think, did it not?

175. 1955.—*Dr. Birch*: Are you considering in this, Sir, the number of sessions?

176. The individuals and the number of sessions, these figures are all in the Ministry's factual memorandum.—The sessions would show quite differently. Many physicians are doing one or two sessions of paediatrics, and a much smaller number are doing whole-time. I think the majority of the amount of work done by the paediatricians would still be done by whole-timers.—*Dr. Hilliard*: The sessions are rather different from individuals.

Chairman: Yes, the figure of sessions is given in the tables.

177. *Sir David Hughes Parry*: A good deal of administrative work is done, obviously, by the whole-time consultants, is it not?—*Dr. Birch*: Above a certain amount it is disadvantageous to him to do it—so there is a tendency for whole-time consultants to get out of administrative work.

178. Would you recognise that there ought to be some extra remuneration

because it is undesirable in that way? Ought it not to be remunerated to make it less undesirable?—It would attract better doctors to that kind of work.—*Dr. Hilliard*: If he is a full-time consultant he cannot be doing more than two-elevenths administration.

179. You do not think the little administration he does matters very much?—It does not matter financially because he is allowed up to two-elevenths. It is only in some hospitals where he is for various historical reasons given half-time consultant status, half-time administrative status, that he gets less money; and these people are wanting naturally to be upgraded to full-time consultant status.

180. I just wanted to make that quite clear.—We do not say these people are more than consultants. They are not consultants for the part of their work that concerns administration.

181. *Professor Jewkes*: I do not know what the Whole-time Consultants' Association has in mind here about methods of preventing the drift, but I suppose anything suggested would not go beyond the point of trying to put into equal balance the salaries of whole-timers and the appropriate salaries for part-timers. Suppose that even when that balance has been struck, and, because of the advantages of private practice, there is still a drift towards part-time. Would you have any idea as to what should be done next?—*Dr. Mayon White*: Yes, Sir. I think it would then be to the national advantage to put the financial inducement in favour of maintaining some of the able people in the hospital service. It is very easy to argue that the man who is making a success of private practice since he is in open competition, is necessarily a very good person; and if perhaps he drives a Rolls Royce it is easy to see he must be good because good surgeons have good cars. The whole-time surgeon driving a Hillman Minx, automatically by comparison seems to be not a good surgeon and that affects the whole thing. There is a natural feeling which is, I think, exemplified by the figures we give you. I think, if you want to keep a proportion of your best people whole-time in the hospitals it is in your interests to see that they are the best people and not those only who could not succeed in open competition.

182. *Chairman*: Is not the merit award system intended, whether it works or not, to do just that sort of thing. It is only given for the amount of work you put in on hospital service?—Our members feel that probably nearly all of them go to part-time consultants because this Association is not represented on many of the central bodies. As an Association we do not know who gets the merit awards, and as individuals we do not know. We think they may go to the people who have the highest cars.

183. *Professor Jewkes*: But no one in fact knows?—No one knows.—*Dr. Hilliard*: If it is published, obviously the recipient is recognised as a person at the top of the tree.

184. *Chairman*: It is a little bit a case of cause and effect, but I presume he gets the car because he has cash, rather than the other way round? Or is it that he finds it a good investment to get more patients?—Yes, I think that is how it works. I think the Income Tax Inspector recognises that that is a business expense.

185. *Sir David Hughes Parry*: Would it be right for me to assume that really you are not opposed to the system of merit award, but you are not very happy about the method of distribution?—*Dr. Mayon-White*: No, Sir, not that we are unhappy about it. I think the profession as a whole very much hopes that you will give us an objective assessment of your views on it. I think many of us, and we in this Association particularly, are a little uneasy about the secrecy. We understand that the method of selection is common to methods of selecting individuals who receive many honours and distinctions, and we have no quarrels with that. We think that probably works well and it is the best way of doing it. But the fact that nobody knows who receives the award strengthens the arguments of all those who are critical of the system. I think that in this case particularly, justice ought to be seen to be done. The medical profession, so disliking anything that looks like advertisement, might easily decide not to publish these names, and we think this has possibly led to the view held so far that merit awards should not be published. If you can review this and come to the same conclusion, or a different

conclusion; if you can just give us an objective view of the system, then I think the profession would be in your debt.

186. *Mr. Bonham-Carter*: In different walks of life there seem to me to be two alternatives to the application of some form of merit award. One is that the whole world knows what A. B. or C. earns, and the other is that a man's earnings are only known by his seniors. Are the witnesses saying that they think the whole world should know where an award is made, or merely that the seniors in the ladder upwards should know? To me at any rate this is rather important and I should be grateful for help.—*Dr. Birch*: I do not think we have considered that point, Sir. We just felt there was too much secrecy in general. We have not thought whether only the seniors should know.—*Dr. Hilliard*: The whole world knows the people who are regarded by the profession as of higher status and they are called consultants. That is all public and everybody knows their salary, but after that, the next lot of seniority is secret.—*Dr. Mayon-White*: Sir, would Mr. Bonham-Carter substitute peers for seniors? Then I think we would be in accord. If within the profession we could know the individuals receiving awards, by and large, whole-time, part-time, paediatricians, ophthalmologists and professors and so forth, we could judge for ourselves.

187. *Chairman*: Would you consider that would lead to internal jealousies in the profession to a greater or a lesser extent? I am not thinking of you yourselves, but the other people in the profession whose estimates of their own ability might be rather higher than those of others.—There would be that sort of thing, there is bound to be, but at least nobody would have anything to hide because it would be open. We do not say at the moment that there is anything wrong with the procedure, but that it is hidden. Many people would abolish the whole system of merit awards because they feel it is wrong that millions of the country's money should be distributed secretly.—*Dr. Hilliard*: It is not a satisfactory arrangement, I think, from the professional point of view.

188. *Mrs. Baxter*: You have not thought of the effect of it from the patient's point of view? Would not the patients require to be seen by the man

with the award, rather than by anyone else?—I think, before 1948 when the teaching hospitals had consultant staff and junior staff in quite clear grades, somebody was the most senior surgeon, and people felt privileged if they had him personally. The public know that certain people are eminent and they may be lucky and have somebody who has been physician to the Queen, or something. These things are known. In any profession it seems to me certain people are accepted as the most senior. The public obviously cannot always have that particular doctor, but in the past they have known who was the senior surgeon, partly from the number of years he had worked at the hospital. In this respect in the Health Service we know who is a consultant and who is a house officer, but we do not know, among consultants, who are regarded as the more senior people by the public or the profession, or whoever it is who does the regarding.

189. *Mr. McIntosh*: If the method by which they were rewarded were better known, would that allay suspicion?—*Dr. Mayon-White*: I do not think so.—*Dr. Hilliard*: We do not really know the method.

190. You would not necessarily know the names?—You cannot tell whether it would be a good thing.—*Dr. Mayon-White*: I think it is true to say we are not so worried at the method. We would take that for granted if the names were published.

191. *Chairman*: By "published", you mean published to yourselves?—Within the profession. We would not have that announced in the public Press, nor used for attracting patients. But one must appreciate, human nature being what it is, that if the thing is a secret and the secret is allowed to leak it will attract patients. The secret system seems open to many different kinds of abuse. I might let hints drop that I received a merit award, whether I had or not, if I wanted to attract patients.

192. There is something that has been put to us in similar ways in different memoranda that we have been sent. If it is rather easy to shift now from whole-time to part-time, and a maximum part-time of nine-elevenths, would you think there is a case not merely for equalising the level a bit more as between the two, but also for saying that eight or seven sessions or something

like that should be the maximum number?—*Dr. Hilliard*: I think, as nobody knows what would happen, our first step would be, if there is no financial weighting either way, to leave it to free choice, but to provide equal pay *pro rata*. If it was a continued drift there might be a question of adjustment.

193. You mean, treating nine sessions as nine-elevenths and not nine and a half elevenths?—Yes, and also the question of domiciliary payments. Either everybody should have to do eight free ones, or nobody should. If all these items that you are aware of were equalised, then we could see how the market lies. If there is still a trend to more and more part-timers, we think it might be necessary for the efficiency of the service to put a little carrot on for the whole-timer.

194. This factor of weighting you would feel is nowhere necessary, broadly speaking?—We do not know the reason for it, Sir.

195. As to the facts?—We cannot see why a person doing nine-elevenths of the job should be given an extra half-day's pay. There may be some very good reason for the thing to be done that way, but that we do not know.

196. Would you be inclined to apply the thing right throughout?—We think so. If there were snags about doing only two-elevenths, perhaps nobody would want to do them. But it is rather having the cake and being paid for it as well if special payments are made that do not seem necessary. We would prefer part-time to be much more part-time. In certain areas there is a need only for half the services of a particular specialist. If you need nine-elevenths you might say it is full-time.—*Dr. Mayon-White*: Coming from the country, I would say there is a point in having a weighting at the lower end. One knows some hospitals that can only give very few sessions to a specialist, and there is no opportunity for him to earn a living by being at neighbouring hospitals because there are none. I think the weighting at the lower end is very necessary to make certain that consultants with very few sessions and practically no opportunities of private practice can be found to fill the appointments.—*Dr. Hilliard*: That is in the interest of the service, not of individuals. You need this person and you have to attract him.

197. *Chairman*: I understand that was the basis.—That would not apply to the nine-elevenths. He might as well go full-time.—*Dr. Cunningham*: I do not think we want to take away any of the benefits of our part-time colleagues—I should hate to give the impression we were doing anything on that score—but if a person is paid nine and a half, that leaves two sessions vacant on the establishment for another appointment. So that the net cost to the hospital has increased by half the cost of one session. I think that must be taken into consideration.

198. *Sir David Hughes Parry*: I want finally to take you to paragraph 13, the whole section on professional expenses, which you have already mentioned. I think the best thing may well be to give you the opportunity to explain to us what the difficulties of the present system are and what sort of sum is involved. I think I had better leave it with you to present in any way you like. Would you tell us at the end what sort of sum it is—£100, £150, £200 or £250? First of all, the question of expenses?—*Dr. Birch*: We have approached all our members to find out figures of what these expenses are. Our Secretary has the figures.

199. Would it be possible to pass that on to us?—*Dr. Cunningham*: Yes. Shall we take it item by item, Mr. Chairman? We sent a form to each of our members on the various items asking each member to let us have in confidence the deficit under this heading after any official expenses payments. I have collated those replies to the best of my ability.

200. *Chairman*: Is it something that can be read out and understood right away?—Yes, it is quite brief. We had replies from 144 members, which we thought a very reasonable figure, considering that we asked for replies inside a very short time. Under the heading of car expenses—I will leave some of my colleagues to elaborate the various points—the members there point out the various difficulties in estimating the question of car expenses. It is very difficult to lay down hard and fast rules on this point; the size of the car, the type of the car, the distance the person lives from the hospital and so on, small and large mileage—my colleagues know these and will elaborate. But of my 144 replies, 122 persons gave expenses in connection

with the use of their cars in the Health Service, and of those members 27 per cent. had a deficit of running expenses of between £10 and £50, 28 per cent. had a deficit of between £50 and £100, 19 per cent. had a deficit of between £100 and £150, 9 per cent. had a deficit of between £150 and £200, and 17 per cent. had a deficit of between £200 and £300. I think those figures speak for themselves. That is one item. I have other items.

201. *Sir Hugh Watson*: These figures include depreciation?—Yes. The present allowances cover ordinary expenses, but not wear and tear on the cars, which is variously estimated up to £200, according to the type of car and mileage per year. They do not cover home to hospital mileage, and that is a very important bone of contention among members who live seven or eight miles away from the hospital. They are only allowed mileage to the hospital on the days of their domiciliary visit. They do not get the mileage allowance.

202. This applies to many persons?—The part-time person with whom we compare these things has half-an-hour's travelling each way, each day, out of a three-and-a-half hour session. We who work side by side with our part-time colleagues feel we are differently treated from them in this respect, and this point is made by the members.

203. *Chairman*: Yes. We are at the moment trying to get the differences between the part-timer and the whole-timer.—Yes, that is what we are comparing, and these are the points of contention.

204. I think we might very likely want later both to see these and to write and ask you for more specific facts. This is the kind of thing we want.—*Dr. Mayon-White*: The whole-time consultant is not expected to own a car. With the part-time consultant, it is acknowledged that a car is a doctor's tool.

205. *Sir Hugh Watson*: Did you say these figures include allowance for depreciation?—*Dr. Cunningham*: Yes, these include the depreciation figure.—*Dr. Hilliard*: The mileage allowance only covers petrol and tyres. Whereas a part-timer will get in his income tax allowance each year so much for a car, the whole-timer does not. They both get the mileage but the part-timer also

gets a large sum for the replacement of his big car, and that is a very big thing.

206. *Professor Jewkes*: So the difference between the two groups is merely a matter of depreciation?—Plus domiciliaries and income tax allowance.—*Dr. Cunningham*: All these points add up in varying degree, according to the varying circumstances of each person.

207. *Chairman*: You are saying these amounts you have made out are the amounts by which your doctor is out of pocket. You are assuming that the part-time consultant, so far as I understand, is neither in pocket nor out of pocket, that his expenses, including depreciation, are met? He does not recover that depreciation from anybody; he only gets back the tax allowance?—He gets an income tax allowance on his deficit. He can deal with his deficit in a way in which it is quite impossible for us to do.

208. Therefore the difference between you and him you think is the tax difference of the actual amount spent. The tax difference can be 8s. 6d. but I gather that the tax against part-time consultants is at a higher rate?—We think it is.

209. You have calculated it at that?—This is purely a person's impression of what his deficit is, having added up his expenses in terms of cash.

210. But the part-time consultant, if he allows £100, say, for depreciation of his car, will not get £100 back; all he is going to do is to be allowed to charge £100 against his net profit, so it is simply the tax on it he will recover? He still has to depreciate his car?—That is one point and, as I mentioned, he has the home to hospital mileage which is a very important point and can be a very high expenditure for a person who lives up to ten miles away from the hospital. The part-timer can get payment up to ten miles each way; the full-time person cannot, and he does not see why he should use a bus when the other person can come by car.

211. *Professor Jewkes*: The figures you quoted represent how much better off the whole-time consultant would have been if he had been a part-time consultant?—No. Not quite that.

212. *Chairman*: No, all they represent is that the man is out of pocket because what he collects from the authorities as payment does not make up for his ex-

penses. In fact, would I be far wrong in assuming that these figures really show that the amount of depreciation on a car normally used is at least as much as most of those figures? The mileage payment makes a contribution to depreciation, but for one reason or another you have brought in other items?—*Dr. Hilliard*: These figures are not in relation to the part-timer. If a whole-time person said "I will not buy a car" he would save this amount of money and perhaps the hospital would have to provide transport. But he obliges by providing a vehicle and he is out of pocket as a result. May he the part-timer is also out of pocket, but the whole-timer has no way of recouping himself at all for that deficit.

213. *Sir Hugh Watson*: These figures, with the best will in the world, cannot be accurate because they are only estimates by your members?—*Dr. Cunningham*: Quite true, they are estimates under confidential cover.

214. I am sure they are reasonable estimates but they are only estimates?—Yes, and we have judged them in relation to our own experience. We can do that, and I think they are very reasonable. The top figure brings in this hospital to home business. We have an actual instance of one whole-time consultant who was asked to provide a car for his work, for professional use and nothing else, and that person did keep all his expenses and so on all the time, doing 9,000 to 10,000 miles per year over the last few years. He estimated that, living somewhere about eight miles from the hospital his loss was between £200 and £300. It was rather an interesting case. If you would like these figures we can supply them.

215. *Sir David Hughes Parry*: It is part of our terms of reference to compare the remuneration of medical men with the remuneration of members of other professions, and therefore we have to consider that you are in the same position as many other full-time salary earning persons. We have to consider that.—*Dr. Mayon-White*: We do want to make the point that we have more need for a car, and a more reliable car.—*Dr. Birch*: I would like to stress the point that in our profession a car is like a stethoscope; it is an essential tool of our practice.

216. You have further figures?—*Dr. Cunningham*: The next item is the renewal of instruments and other equipment. Only 31 out of the 144 replies reported expenditure under this heading. Of those 31, 29 had an expenditure of up to £10, one had between £10 and £20, and only one person had over £20. The latter was a portable X-ray apparatus. So it is not a very big item and the point was, most of the people felt they had to depend on other ways of getting their equipment. They have gradually built it up, partly from the hospital where they work—not a very satisfactory arrangement.—*Dr. Mayon-White*: It is a fact, provided we plug away at our committees for long enough we can get most of the clearly essential medical equipment through the usual channels. What we usually do is to buy it out of our own pocket and eventually get reimbursed by the hospital. By and large, that item of our expenses is covered, but a new car is not recognised, and we cannot get that one.

Dr. Cunningham: Books was the next time. 106 members reported under this heading: £0—£10:79, £10—£20:20, £20—£30:7. In other words the great majority were less than £20 out of pocket per year. A number replied to say that they could not afford to buy books, etc. These were the actual figures of expenditure.

217. There is no allowance by the income tax authorities on that?—There is no allowance under this heading whatsoever. Journals, subscriptions to scientific societies: 139 members reported annual expenditure under this heading. In five cases there was nil expenditure, two reported that they had good library facilities in the local hospital, and the others said they had lost interest, or something to that effect. Up to £20 per annum—86 £20—£30 per annum—39, over £30 per annum—14. In other words, 90 per cent. of the members spent up to £30 per annum on these various societies, medical journals, etc.

218. They do not get any allowance for this at all?—*Dr. Hilliard*: Under Schedule E, only if you belong to a particular one of the medical societies. On my Schedule E income tax I am allowed £2 expenses for the whole year, but any books, library subscriptions etc. are completely washed out.

219. Is this one area?—This is all over England and Scotland and Wales.

220. *Chairman*: Do I gather the part-time consultants, even those who are nine-elevens, get all their books?—Yes.—*Dr. Cunningham*: Some of our members reported that they do not even get the £2. Some Inspectors have clamped down on that. That seems very unreasonable.

221. *Professor Jewkes*: That is a very interesting point because apparently the habits of Income Tax inspectors vary.—*Dr. Hilliard*: I think they vary very little on Schedule E but many of us, the more senior people, give lectures and write books and come under D as well and then we do receive allowances. But two of us in the same district, working on exactly the same number of lectures and books and so on will get something quite different. I think it is unfortunate when the Exchequer do not give all the assessors the same rules. It is very upsetting when two doctors are assessed quite differently on these other aspects of Schedule D. We went into this, Mr. Chairman, when we gave evidence to the Royal Commission on Income Tax. That was one of the points we made.

222. *Sir Hugh Watson*: On that subject you are aware that this is being looked into at the moment not only from the point of view of the medical profession?—But because we are both working in the same hospital it is much more disturbing. All sorts of professions have this problem but you do not get the whole-timer and part-timer working side by side so much.

223. *Chairman*: On many of these things, if they were interpreted for whole-timers and part-timers in the same way, many of your resentments would go, apart from the actual money involved?—Yes.—*Dr. Mayon-White*: I think very probably, Sir, we should spend more. This is the minimum rather than the optimum. Each time the subscription to a journal goes up or the school fees go up, that may very well affect not only oneself but one's colleagues. We have in Ipswich a very good medical library started since the Health Service. The further you live away from London, the more difficult contact with your colleagues is, and the fewer there are in your specialty in your area, the more important it is to keep yourself up to date, and the bigger your

contribution in these expenses should be.—*Dr. Cunningham*: I would like to report one other point and say that 14 of our members specifically said they had resigned from certain societies and stopped taking certain journals because of financial difficulties. I think that also should be stated.

224. *Sir David Hughes Parry*: Is there any other item?—The next item is the preparation of scientific papers, including the use of a study room, clerical assistance, printing, etc. Most members reported negligible expenditure. A few were out of pocket up to about £95. £50—study, £25—secretarial assistance, £20—reprints of various articles. Some members reported they had already received income tax allowance against this expenditure from the local income tax authority, but the great majority received no allowance whatsoever.

225. That is a more difficult matter, is it not?—Quite a number of members do lectures and that sort of thing. It is a definite legitimate expense, I think, for most people. They should be encouraged to do these things rather than discouraged as they are at present.

226. I do not think even the university professor gets this either.—*Dr. Mayon-White*: No, Sir, I do not think he does, but these are the points of difference between ourselves as whole-timers doing our studies at home in the evenings and our colleagues who have consulting rooms in their houses and can get a certain amount of housekeeping expense allowance on their business premises. We by choice do not do business in our houses but we are giving evidence on the financial discrepancy between the two.—*Dr. Cunningham*: The cost of reprints is an item that should somehow or other be covered.—*Dr. Hilliard*: The time and the cost of this we think, Sir, is expended in the interest of the service. We do not advertise ourselves by sending reprints round to other people, but if we write an important paper and get requests from other people for it, we feel we ought to be able to supply it without expense in the interests of the service.

Dr. Cunningham: The next item is stationery and postage. This is a very small item. One or two cases amounted to £10. A very small item and we need not elaborate that any further. A lot of

the expense is in connection with postage on books and papers to the Royal Society of Medicine, for example. The member has to bear postage on these sort of things. If you borrow books from the Society you have to pay the postage.

The next item was telephones: 119 members reported expenditure under this heading at a figure generally estimated at between £5 and £20 per annum. In some extreme cases either because the member was the only consultant of that specialty in the area, or because of additional responsibilities, there was even greater hardship, where expenditure was somewhere between £50 and £100 per annum. A point generally made by these people was that the duty of answering telephone calls generally falls on the wife.

The next item—expense of attending national and international meetings, and the expense of visiting hospitals and clinics at home and abroad. We had rather a poor response under this heading. Many members deplored the fact they could not afford to attend as many meetings as they felt desirable in the interests of their specialty, but a few enterprising individuals have gone abroad to international congresses and have found they were sadly out of pocket as a result. One member spent £150 in one year, another spent £150 on a visit to America, a third £105, a fourth on a visit to the United States spent £400, £200 of which was granted, leaving a deficit of £200, and a fifth visited an international congress at a cost of £450 and so on.

227. *Chairman*: When you say "£200 was granted", does that mean paid by the Service towards his cost of going? —From an endowment fund.

228. It was not a charge against tax? —It was a payment from an endowment fund, leaving him still £200 out of pocket. Another man spent £450, paying it all himself with no grant at all. Apart from this endowment grant which I have mentioned, a few members were allowed to go on full pay but without expenses.

229. *Sir Hugh Watson*: Were they invited by the National Health Service to go?—No, they asked to go themselves.

230. Could I put it this way? Did they represent to the competent authority that it would be good for them, and for

the hospital service, if they attended this particular course or series of lectures? —I did not go into this.—*Dr. Hilliard*: They were given permission to go.

231. For that very important conference last summer in Sweden on the question of tuberculosis, and so on, your people were not allowed any expenses at all?—*Dr. Mayon-White*: No, Sir. —*Dr. Cunningham*: None of the people who replied to me.—*Dr. Mayon-White*: Could I explain how it works? The whole principle of study leave is simply based on the system used by the Medical Research Council. If you are contributing a paper at the meeting, then you will be allowed leave of absence with salary, and a grant towards your expenses. If you go to learn you will not be paid any grant towards expenses, though your salary will be paid, and you will be allowed leave of absence. If it is thought by the Regional Board when you make your application that you are really going more for your own amusement than for the Board's benefit, they may say: "We will give you leave to go, but we will stop your salary during that time". Alternatively you go and count it against your annual leave. The category in which most of us attending these congresses come is study leave with pay, but without expenses. That is to say our presence there is clearly to the Board's advantage. They are encouraging us to go, and they will occasionally give us a letter to say that we have their permission to go. Again it is up to the individual income tax inspector to decide whether or not in the case of a salaried worker he can allow that. In my case he will not. In eight years I have been abroad once for ten days, and it cost me £105. That is the total of the school fees I pay for three girls at local day schools in two years. So I have to weigh the cost of a good holiday for me against the school fees. These are personal statistics to show there is no relief of income tax on this kind of professional expense.

232. *Chairman*: To come back to the comparison with the part-timers, if the part-timer takes some time off from his job to go to America to attend a conference, presumably he loses in effect his remuneration from his private practice for that time, because presumably he is not operating or consulting. I am not quite sure I see in this

particular case the disadvantage incurred by the whole-timer.—*Dr. Birch*: I do not think it is always true. I think a part-timer can go and get leave with pay from his Board.—*Dr. Hilliard*: He may get private tax relief on the expense of going to America.

233. If he gets leave from the Board.—He gets his salary from the Board.

234. I am not disputing your point but I have not seen yet where in this particular category your people are at a disadvantage in comparison with part-timers.—On the tax basis. A part-timer can go for the benefit of his practice to this conference, knowing he will be allowed to charge the cost of going there against his expenses, and he will get tax relief on the expenses.

235. Would the expenses include the cost of the locum?—It might.—*Dr. Cunningham*: It might allow for a locum, but very often there would not be locums for a short term. I think the point is that each of us gets six weeks' holiday each year, and if you can link up your conference and so on with part of that six weeks' holiday, then I think you can work it quite satisfactorily.

236. *Sir Hugh Watson*: The part-timer gets six weeks' holiday in the year?—Exactly the same amount as we do.

237. *Sir David Hughes Parry*: Is that all the expenses now?—On the last question we put in our inquiry—the expense of entertaining visiting colleagues—50 members reported expenditure under this heading between £5 and £20, in eight cases over £20 per annum.

Chairman: Perhaps you would be good enough to let us have copies of those figures. I think probably we have most of it fairly well, but looking at the total you give us a slightly different impression. We shall want to do a few calculations to see how much it works out at after making allowances for tax, but those are just the kind of facts and figures which we want. Thank you very much for the trouble you have taken.

238. *Sir David Hughes Parry*: Could we move forward to the next section, that is domiciliary consultations. We have touched upon this before. You make a statement, do you not, that this concession was withdrawn within a few months of the inception of the National Health Service?—*Dr. Birch*: The

original system of payments only lasted for a very few months.

239. For a few months?—A few months, and then they were withdrawn. Then there was a long period of several years of negotiation with Committee B, and eventually the present arrangement was accepted by us whereby we had eight free visits each quarter, and were paid only for those above that number.

240. Your suggestion?—That we should go back to the original system where everybody, part-time or full-time, gets the same fee for domiciliary visits.

241. You would not mind whether you still had to do eight free visits, but simply suggest that the system by which you got paid should be the same as for part-timers?—*Dr. Hilliard*: We do not want to do anything to disturb the part-time conditions of service. We just want to be treated the same; we are not asking for the part-timers' earnings to be reduced. It is a good thing for them to be paid for every domiciliary visit. We feel that is all right. But the discrepancy does attract people to switch over to part-time.—*Dr. Birch*: I think the fact that the whole-timer does not get paid for some domiciliary visits somewhat deters general practitioners from calling us in, and to that extent it would be better if everybody was paid for all domiciliary visits.

242. *Chairman*: From the point of view of the patient?—We do know that some doctors do not like to call us out when they know we are not getting anything for it. We certainly found that at the beginning when payments were discontinued. I think most of our members would say that the numbers of domiciliary visits that they did after that fell to practically nil. We were not employed.

243. *Sir Hugh Watson*: Is it true to say you do not like to be called out because you do not get paid for it? Would you mind being called out?—I do not think that comes into it. I think you do it. When you have done six, then perhaps you hope soon to get over eight.

244. You said just now medical practitioners hesitate to call out the whole-time consultant because he has to perform his eight domiciliary visits before he gets paid?—Yes.

245. My question really is in fact would the whole-time consultant really object to being called out?—No.—*Dr. Mayon-White*: No, Sir.—*Dr. Hilliard*: We can and do do them.

246. The general practitioner's feeling is unfounded?—He feels it seems a bit hard to call on somebody who is not going to get anything for it.

247. *Professor Jewkes*: This might lead the general practitioner to call the part-time consultant rather than the whole-time consultant, other things being equal.—*Dr. Hilliard*: They are getting a good consultant, but there is another good consultant who is full-time and can never go out.—*Dr. Mayon-White*: Most of my domiciliary visits, for example, are made in the evenings and at the week-ends. I cannot go on a visit involving 90 miles of motoring, and perhaps three-quarters of an hour at the bedside in the course of the ordinary working day. I have a pretty full day as it is, and that kind of visit must be made in the evening or at a week-end. It is true that the general practitioner is apt to turn to me and say, "Is this paid for under the Health Service or not?". If he finds that it is not—there is no part-time competition for me in my area—what he does is to apologise to me for that occasion and next time he sends the child into hospital, and does not bother to drag me out at week-ends. The child if he sends it in, is served equally well, but he costs the country money. I have analysed my last year's visits, in all 71, and I find that 57 of those either recovered or died at home. That is to say they were never in hospital, and I think we may assume that it was not necessary to put them into hospital. Eleven of them came in subsequently, often many days afterwards because of some complication, but they were not just visited at home and brought straight into hospital. Only three of the visits out of 71 can I really think were unnecessary and were time wasting from my point of view. Really one has only wasted three out of 71, and the answer to your "would we go?" is "Yes", because we do meet our friends, our g.p. colleagues, and talk our subject. Domiciliary visiting is an enjoyable thing.

248. *Chairman*: You talk about 90 miles. The average for those 71 visits I suppose would not be 90 miles?—

It is just a fraction over 20, counting those in my own town.

249. Ten each way?—Ten each way. May I mention another difference between us and the part-timer which we do not mention in our memorandum. Our part-time colleagues are allowed additional mileage for every 20 miles over and above the first 20, and we do not get that. We are allowed four guineas whatever the distance.

250. That is really supposed to be related to the time involved, is it?—Yes, Sir, but I do not drive any faster, the time is the same.

251. You are whole-time employed ... ?—Yes.

252. ... just as I and many of us are in our jobs?—I look at it this way. My part-time colleague is either going on a Health Service domiciliary visit and being paid a Health Service fee, or he is going in his own time, and is charging a private fee. I would have thought that that private fee would include the loss of private earnings in his private time. I cannot see why the Health Service should pay him more for his service to the Health Service than it pays me, unless I am giving a second quality service. We do feel with these slight differences in financial reward there is a growing feeling that your whole-timer is a second eleven kind of man, not quite the best kind of specialist.

253. I think we have the point. I think we would find it hard to believe that our visitors today were only in the second eleven.—*Dr. Birch*: In some areas there are no beds available to the part-time consultant. If, for instance, there is just the whole-time consultant available, then if he is deterred from visiting the interests of the patients in that area are not met, because they cannot get the facilities at his hospital where he is employed full-time. I know cases where part-time consultants have to see a patient and the hospital that they have had to use and eventually get the patient into has been quite a distance away; and patients do not like going to hospitals at a distance. I think that is against the patients' interests.

254. When you send us this little catalogue of all the differences, it would help

me, and I daresay my colleagues too, if you are able to divide it into those that are taxation points, and those that are points of substance in themselves apart from taxation, if you see what I mean? I think most of them are taxation points, but not quite all. If you would have a look at that?—*Dr. Cunningham*: In elaboration of the domiciliary visits, I think some of our members did make a point that the fact they were not paid was a financial deterrent. They felt they were out of pocket already on car expenses and did not see why they should be further out of pocket for 32 free visits. It does not apply to all, but it does apply to some. We asked our members some questions in connection with domiciliary visits. We asked them how many they were doing before the free visits were brought in and afterwards, and we asked them to analyse it in various ways. We found 66 per cent. of 82 who replied were still doing under 32 visits per year; in other words 54 per cent. were still within the free number, and were not getting payment.

255. Would it be reasonable to say in some specialties there would in any case be very little domiciliary visiting?—I think that is true.

256. So the national average of 32 is not really the national average of those who were likely to be visiting?—*Dr. Mayon-White*: No, it would include people like radiotherapists who might not be called out once in a year.—*Dr. Cunningham*: That was our figure, 66 per cent. of the 82.

257. *Professor Jewkes*: Could you say the average number of visits that were covered by the consultants?—We have an average figure for all of them. Fifty-four were doing 32 visits and under, 17 were doing 32 to 100, 9 were doing 100 to 200, and 2 were doing over 200.

258. *Chairman*: Would you mind checking and seeing if you can give us what were the specialties of the 32 and under?—Yes, I think I can do that.

259. *Professor Jewkes*: I wondered if you could possibly work out for us the average figure when you send us the statistics? It would be useful, because it looks almost as if the number of domiciliary visits by whole-time consultants is on the average higher than for

part-time consultants.—*Dr. Hilliard*: I think one must say that these are based on the returns of the questionnaire, and it may be the ones that do not do it did not bother to reply. We do not want to stress our enquiry too much; statistically it is full of problems.

260. *Sir David Hughes Parry*: Senior Hospital Medical Officers, paragraph 20—that is the only other matter. You really suggest raising the standard of pay for them after they reach what is now a dead end. Is it implicit in what you say that you think that every one of them should in due course be promoted in effect to the rank of consultant?—*Dr. Mayon-White*: No, Sir.

261. I am not quite clear, and I do not think the Commission is quite clear, what you have in mind.—We would like to make certain that every Senior Hospital Medical Officer feels that he has a good chance of becoming a consultant eventually, and that he is not put in to stop a gap and to remain in the subordinate category of specialist. It is thought by Senior Hospital Medical Officers generally that their chances of achieving consultant rank are very small, and that they are likely to be passed over every time they come up for appointment by some senior registrar holding a job in a teaching hospital. That is what they mean by the dead end nature of their job. I think this Association particularly would like to see two things. The first is to make certain that their salary is sufficient to make a career grade for those who will never reach the top rank, and we recognise that there must always be some people like that. Secondly, we would like to think that everybody has a feeling that even at the age of 60, shall we say, if he can satisfy the requirements for the jump to consultant, he can be promoted there.

262. *Professor Jewkes*: This implies, does it, that there would have to be more posts for consultants? If you are going to facilitate more rapid promotion of any one group you have to conceive of more consultants' posts being created?—I think anybody who is familiar with hospitals would say the service we have at the moment was a very good first approximation to the country's needs, but that now is the time to recognise that the first approximation is never quite right, and that there are adjustments to be made. There is room for more medical

manpower in the consultant ranks, and it is possible that there is need for a subordinate rank—call him specialist—for everybody for ten or twenty years before they become consultants. We have tried to give some expression to those feelings in this paragraph.—*Dr. Hilliard*: There has been a back log, because at the beginning they did not make as many consultant posts as they might have done. The S.H.M.O. was I think meant to be a stop-gap, but it has gone on permanently and certain hospitals have an establishment of S.H.M.O.s who are virtually doing the same job as the consultants. It is a very good training ground. Personally I would like to see the S.H.M.O. as more or less the automatic way of bringing up consultants.

263. If you promoted the Senior Hospital Medical Officer to be a consultant on the ground that he is already doing consultant work, you do not alter anything as far as your case is concerned?—No.

264. That would be a question of promotion on account of equity. But that is quite a different argument from the argument that in fact we are short of people of consultant status, and that we ought to extend that number. I wondered on which particular ground you were really advocating the more rapid promotion of the Senior Hospital Medical Officer? Perhaps both?—*Dr. Mayon-White*: I think on both, and I think we would emphasise that we are not advocating necessarily the more rapid promotion of Senior Hospital Medical Officers. We think that amongst those people are very many who will never reach consultant rank, but it is almost implicit in the appointment that none of them will ever reach consultant rank.—*Dr. Birch*: They are not all quite as dead as each other. In pathology, for instance, the S.H.M.O. chap is not in quite as dead an end as in general medicine, or in some other specialties.—*Dr. Hilliard*: In certain hospitals they had a staff, and when the new N.H.S. grading brought the new conception of the consultant, these hospitals found they had to have the S.H.M.O. doing the work because they could not afford to have all consultants. But the new appointments should be just as good as the consultants of the previous generation.

265. *Sir Hugh Watson*: Some S.H.M.O.s would in the normal way gravitate upward, but some you would prefer to be barred where they are?—*Dr. Mayon-White*: Not necessarily barred where they are. I should say they should be made more content to stay where they are, that is to say their income should slightly exceed the junior consultant level. It should be a career grade with a pension at the end.

266. Would you favour the creation of an intermediate grade between S.H.M.O. and consultant?—I would, personally. It is a very personal matter. I think it is wrong myself that at 32 my appointment was as a consultant, because I was brought up to believe a consultant was a senior member of the profession. Call me specialist, because I have had specialist training, and after some years of experience in the specialty, ten, fifteen or twenty, then designate me consultant. Perhaps call us all specialists until we have merit awards, and then call us consultants. I think it would be very much healthier.

267. *Chairman*: I would like to know whether that is broadly the view of the Association, or whether it is too unfair to ask?—*Dr. Birch*: We feel there is a need for perhaps an intermediate grade between the consultant and the present senior registrar. There is a good deal of work in hospitals that can be done by a person who is not a consultant, but this is more than the senior registrar can take on. At present there is a lot of work being done by the senior registrar which we think should be done by consultants, and there is a need for more consultants in the country. We know that a few years ago eminent members of our profession visited hospitals all over the country to look at the needs of the service. They made a report, but I do not think it has ever been disclosed what the findings were. When we look at our hospitals the differences in the staffing are quite noticeable.—*Dr. Cunningham*: You asked did we favour something between the S.H.M.O. and the consultant. I am not quite sure that that is . . .

268. *Sir Hugh Watson*: Between the consultant and senior registrar.—We would like to feel an assistant consultant grade took the place of the present S.H.M.O. grade and was the natural stepping stone to consultant status.

269. *Chairman*: With plenty of people staying?—With the possibility that quite a number will be content, with the salary adjustment, to stay there for the rest of their lives just because they prefer hospital work to other kinds of work.

270. That brings us to a point directly on remuneration. If I have interpreted your views correctly you would feel that somebody who became consultant at, say, the age of 32 would probably start at less than somebody who was S.H.M.O. at the age of 45?—Yes.

271. Would you think that the present number of annual increments or biennial increments comes to an end rather soon? For instance if a man becomes a consultant at 32 he will never get an increase after 40?—*Dr. Mayon-White*: Yes.

272. I was wondering whether as part of this picture of the ladders you would envisage—even if you reach the same ceiling, or one slightly higher—that it might be better to have increments spread out over a longer period?—*Dr. Cunningham*: We have not really discussed the whole details of finance; we did not think that was our province. We felt the top scale of the assistant consultant grade should overlap the consultant scale through three or four, or a certain number of increments, but we did not want to be specific on that particular point.

273. At whatever age when he went from one grade to the next he would get an increase?—Yes.—*Dr. Hilliard*: The senior man who has got stuck at S.H.M.O. will be getting more than the consultant at 32, so it does make a career grade for the senior post man and not a dead end with the stigma that is attached to every S.H.M.O.

274. The two ladders might be 10 or 15 per cent. apart?—Yes.—*Dr. Cunningham*: In the hospital service we have noticed very definitely during the last few years that the middle grade of the medical establishment is nothing like as strong as it was. That is why we have advocated this assistant grade to strengthen the medical establishment. After all it is a 24 hour service night and day, and if you have competent people in the middle it strengthens the service very considerably.—*Dr. Mayon-White*: Do we need to say we should need adequate safeguards of ratio? We would visualise something agreed on the lines of a provision for one consultant to two

specialists. We would not imagine a hospital staff of 20 specialists and one consultant. There is a feeling in the profession that if we were to agree to a new grade it might have the effect of diluting the consultant grade.

275. We felt that was implicit in your suggestion about the new grade.—*Dr. Hilliard*: On those terms. It is not just an easy way of cutting the cost.—*Dr. Mayon-White*: We are in favour, and we think our colleagues are in favour of something that is evolved along those lines.

276. *Professor Jewkes*: I think you mentioned that in the medical grades in hospital staffing there were weaknesses. Why is this?—*Dr. Cunningham*: I think at the present time it is very difficult to fill the registrar grades in the non-teaching hospitals, for the very simple reason that the registrar grade there leads nowhere. I am talking of the specialties where the S.H.M.O. is not allowed, and it is particularly important there. The hospitals that have senior registrars or late senior registrars are quite happy, they are strong in the middle. But at many hospitals throughout the country you will find on enquiry that the registrar level is weak. In other words there are house officers and then there are consultants, and there is very little in between. We feel that the registrar grade should be strengthened by a better salary system than we have at the present time.

277. One possibility would be to improve conditions for registrars?—That is one way of doing it, and the assistant consultant grade would be one possibility of drawing people back again. There are various ways which might be tried, but we feel that is part of a much bigger thing and probably covers the whole profession.—*Dr. Hilliard*: The registrar is a temporary appointment, and the trouble is you cannot run a hospital with everyone having to go at the end of two or three years. If there was a more permanent intermediate grade which was waiting its time to move up it would give the hospital staff a feeling of greater stability. It is very disturbing to everybody when people are constantly changing at this most crucial level of registrar.

278. *Chairman*: I think we should say that has been brought home to us

very forcibly in many memoranda, this difficulty of the registrar.—He is not financially secure when he gets to the end of his four years and has the difficulty of moving, the expense of a family, and everything else.

279. We have not touched on the general level of remuneration of the profession as a whole. Do I gather that you think it is completely satisfactory at present?—*Dr. Birch*: We thought we would not go into that one. We deal in general principles affecting our particular status.

280. In that case we come to one other point of some importance, and that is on the whole do you feel that the existing method of negotiation through Committee B of the Medical Whitley Council is satisfactory as a system? If not have you any suggestions to make as to an adjustment of the system? It is rather an important matter. We do want to make sure that you do not have to have any other Royal Commissions in your lifetime!

—*Dr. Hilliard*: Whatever is laid down for the profession as a whole, we would like to see adequate representation of the interests of the whole-timers in Whitley meetings. We do think sometimes that problems on the actual day-to-day life of the whole-timer are not so clearly put forward by the members of that Committee. I think a lot of them are part-time and only a few whole-time; they are not really familiar with the whole-time problem. I think whatever system you have for negotiating the remuneration of the profession in which there is a large group of people who are whole-timers, their interests should be clearly put forward with the best arguments. I think our members feel sometimes they have not had a very good deal in this respect.—*Dr. Birch*: On the 32 free visits question, we only had one opportunity of appearing.

281. Was that at the Whitley Council meeting?—We did have one opportunity.

282. You were appearing as it were in front of both sides of the Council, making your case to both sides?—We met the staff side in the morning, and then met the whole Committee later.—*Dr. Mayon-White*: The staff side took us as their witnesses; they were arguing the case for us and giving us the chance

to provide supporting evidence. May we instance that the matter of our income tax allowance for professional expenses has been before Whitley B since the Health Service began. We believe our part-time colleagues have done their best to get the management side to agree that a doctor may incur certain professional expenses as a whole-timer. If we can get that agreement also from the management side we feel that the Inland Revenue inspectors would accept it, but the management side have said: "No, every whole-timer can get every professional expense met out of the hospital because that is what the whole-time service means; if everything is met out of his employer's contributions then there is no claim for income tax." If you ask the Ministry of Health it is a Treasury matter, and the Treasury say you have to go to the Ministry of Health, and this has gone on ever since. I think it is pretty true that all our affairs really touching on Whitley machinery have never seemed to have very much prospect for the future. They go up to a certain point, and then back again, and there are no means of cutting the vicious circle.

283. You would feel if you had direct representation at any rate. . . .—We should fall by our own fault.—*Dr. Hilliard*: We would stand or fall by what we had the chance to say, but the part-timer is not perhaps the best representative on the full-time problem.—*Dr. Mayon-White*: I think it is also true that we would now like to see some alternative to Whitley machinery like that suggested by Lord Moran in his letter to *The Times* a few weeks back. I think we have no confidence in Whitley machinery as it has worked so far.

284. I thought I had a different answer from that. I thought I got the answer that Whitley was all right but had not got quite enough whole-time representation on it?—No, Sir.

285. You say if there has to be Whitley it ought to have more whole-time representation, but you do not like Whitley?—We do not like Whitley for two reasons. It does not help us. We have not had as big an opportunity to put our case as we might have liked.

286. And an alternative to Whitley?—Something along the lines suggested by Lord Moran.—*Dr. Cunningham*:

That is a personal thing. Our Association has not considered that.

287. We shall not, I think, be asking you to appear before us again, but if your Association would like to consider this point and send in any views upon it, it might help.—*Dr. Mayon-White*: Thank you.

288. I do not want to press you to if you feel it is ultra your constitution or your wishes, but if you would we should be very glad to have it.—*Dr. Hilliard*:

Our Association is primarily concerned with special aspects of the National Health Service affecting its members, and so I do not think that we could really provide you with anything on this.

289. You may not be able to?—
We will look into it.

290. Any views on this will be useful.
—We will do our best.

Chairman: Then we have come to the end of the points we wish you to elaborate.

(The Witnesses withdrew)

Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

2

Second Day, Wednesday, 18th December, 1957

WITNESSES

Joint Consultants' Committee



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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

SECOND DAY

Wednesday, 18th December, 1957

Present:

SIR HARRY PILKINGTON (*Chairman*)

MRS. K. M. C. BAXTER

MR. A. D. BONHAM-CARTER, T.D.

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

PROFESSOR JOHN JEWKES, C.B.E.

MR. I. D. MCINTOSH, M.A.

SIR DAVID HUGHES PARRY, Q.C.

SIR HUGH WATSON, D.K.S.

MR. S. WATSON, C.B.E. (*afternoon
only*)

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

Memorandum submitted by the Joint Consultants' Committee

Explanatory statement for the information of the Royal Commission on Doctors' and Dentists' Remuneration regarding the organization of the medical profession, and the background of the present dispute with the Government, with special reference to the hospital service.

Medical Education and the Entry of the Doctor into Hospital and Consultant Practice

1. The Royal Commission may welcome some reference to the choice of medicine as a career. The situation has changed during the past few years in that now nearly 70% of medical students receive grants from public funds to assist their education. The vocational aspect of the choice is possibly tempered by various other considerations.

2. The length of the medical training has been extended. It should be realized that it takes 6 years (7 if the pre-medical phase is included) before a young doctor can be independent and begin to earn an income, and thus obtain some monetary return for his training.

3. There is a great competition to-day for entry into medical schools, thereby giving the medical school authorities a considerable task in the selection of entrants. An average figure for student wastage from all causes is probably about 5%.

4. The Joint Consultants' Committee has, nevertheless, received *prima facie* evidence from various authoritative quarters that schoolboys of the highest ability are not those most commonly drawn towards a medical career to-day and that the intrinsic ability of the average medical student is not as high as it might be. Some are of the opinion that it is actually falling.

5. All newly qualified doctors must now serve a year of provisional-registration "House" appointments. This undoubtedly helps to raise the standard of ability of the newly qualified doctor, but there can be no doubt that it is desirable for the young medical practitioner, whatever branch of the profession he is going to follow, to serve for another year or more in post-registration "House" appointments. Two or three years of "House" appointments, including the provisional-registration year, are of

irreplaceable value in increasing the standard of professional efficiency prior to entrance into general practice. No amount of subsequent post-graduate instruction can ever replace this fundamental training of the general practitioner. A very much longer period of competitive hospital training is needed for the young doctor who hopes to become a consultant.

6. A consultant can be defined as an expert who has undergone competitive and extensive post-graduate hospital training in posts of increasing responsibility and who has obtained the higher qualifications which are recognized by the profession as essential to the attainment of his status, such as, for example, a fellowship of a Royal College of Surgeons in the case of a consultant surgeon, and who is regarded as suitable to have final responsibility for diagnosis and treatment or for the charge of departments.

7. The basic branches of consultant practice are those of medicine, surgery, and obstetrics and gynaecology. With the progress of medicine a number of specialized branches have been evolved to work in association with the main clinical branches. Radiology, pathology, and anaesthesia may be quoted as examples of these and each of these departments has to be staffed by doctors of consultant status. In addition a number of highly specialized branches have arisen in recent years—cardiology, neurology, neuro-surgery, plastic surgery, and thoracic surgery are examples of this and the consultants in these specialties have had to undergo a further advanced training.

8. The profession did consider whether there should be a division of consultants into two grades when the National Health Service was being planned but it was decided that this was disadvantageous and that all consultants should be in one grade.

9. The holding of competitively obtained junior hospital appointments of varying grades, which is the basic nature of the training to become a consultant, consists of several years of "House" appointments followed by posts in the different ranks of registrar in the appropriate specialty and, maybe, related specialties.

10. Seven years may be regarded as an average period of time for which training posts should be held after full registration. Many fully trained and qualified men now find difficulty in obtaining consultant posts and their future is anxious and uncertain.

11. The one registrar post which is specifically regarded as a training post for those approaching consultant status is that of senior registrar (see Consultant Spens Report) and this post, in an attempt to avoid undesirable wastage, is restricted in numbers, both as a grade and in the different branches, by the Ministry of Health in discussion with the profession.

12. The attainment of consultant status as defined above only takes place when, in open competition as laid down in the regulations, the doctor wins an appropriate permanent post on the staff of a hospital.

13. It will be appreciated that although registrars are now better paid (again, see principles of the Spens Report for consultants) than they used to be, the competitive process of becoming a consultant is exacting and will always rightly remain so.

14. It is most important, on the other hand, that a man of consultant quality should reach his consultant post at as early an age as possible in order that he may give his best services over as long a period as possible.

15. The Joint Committee agrees with the recommendations of the Spens Committee that the average age for achieving consultant status should be 32 years. Against this, the competition for posts since 1948 and the slowing down of expansion have had the unfortunate result of raising the age of appointment to consultant status considerably. Many men of adequate calibre are now not appointed until they are 40 years or more of age and considerable efforts and planning are required to alter this.

16. The profession is aware of the dangers of premature specialization and is insistent that the aspiring consultant should have an adequate period of basic training in general medicine and surgery, even if he aims to practise later in a comparatively narrow specialty.

17. The two years of military service have lengthened the preparatory period of training and added in various ways to the difficulties. For example, it has not been easy for a comparatively well-paid service medical officer, often married and with a family, to return to a less well paid hospital post. Presumably this problem will progressively decline with the modification of National Service.

18. Owing to the severe competition and uncertainties that face registrars, it is not surprising that there are fewer applicants for such posts to-day than there were in the early days of the service, when applications were numerous and there was an atmosphere of expansion and a strong hope that most registrars would become consultants.

19. The difficulties of recruitment of registrars have increased and would be greater if it were not for increasing difficulties in entering general practice.

20. The manner in which the consultant serves the community and medicine is, as described later in this memorandum, by assuming the actual charge of patients and departments in hospital and by receiving these patients either in the out-patient department or as in-patients from the general practitioners. A few will come directly under his care from the hospital casualty department.

21. On completion of the investigation of a patient the consultant will advise the general practitioner on the management of the case or if expert treatment is required will treat the patient in one of his hospital beds or as an out-patient.

22. He will also assist the general practitioner by seeing his patients in consultation in the home under the domiciliary consultation scheme of the National Health Service or as private patients.

23. There is a variation throughout the country in the amount of private consultant practice carried out and there is variation between the different branches of consultant practice. It can be said, however, that the volume of private practice as a whole is substantially less than before the service came in, and that hospital salary is to-day the main source of income of most consultants.

24. Other functions of consultants, as the highly qualified experts in medicine and surgery, are the teaching of undergraduate and postgraduate students, prosecuting and controlling research and assisting the progress of knowledge in their specialties. They have to organize the work of their departments and keep abreast of developments in their subjects by attendance at medical meetings, study of the literature and so forth. Much of this is well described in the Consultant Spens Report.

Background of the Present Dispute with the Government upon the Question of Remuneration

25. The following paragraphs deal with the history of events leading up to the present situation. Before the war hospital medical staffs could be divided into two main groups. Those from the voluntary hospitals, and those from the hospitals belonging to the major local authorities. This division was a very long-standing one as prior to the Local Government Act of 1929 the general hospitals, which at that time became local authority hospitals, had been Poor Law Guardian hospitals associated with the workhouse and the Poor Law, and as such had been in existence for two generations.

26. The voluntary hospitals, which included the undergraduate teaching hospitals, were traditionally staffed by consultants of high calibre and were responsible for the real and actual care of patients and the efficient working of the various departments. Their work in hospital was unpaid and they derived their incomes from private practice. The honorary staff, whose appointments were permanent and made as a result of keen competition, were assisted by a relatively few, more junior but well trained men and below these by a staff of recently qualified house officers, all these assistants holding posts of limited duration.

27. The house officers in voluntary hospitals received their board and lodging, but little or no salary. The posts were keenly sought as an essential measure of post-graduate training for any good doctor, no matter whether he was aiming at general practice or specialist work.

28. The intermediate grade, known by such titles as resident medical officer, registrar or chief assistant were frequently in possession of higher qualifications and looked forward to their period in this grade as training for consultant status. They were usually non-resident and were paid salaries that at the best were hardly adequate for ordinary subsistence. It became increasingly obvious that if these aspirants to consultant status were not relieved from some of their financial difficulties a number of the most able graduates might be prevented, on economic grounds, from proceeding towards a consultant career. The Health Service has done much to remedy this problem.

29. The medical staffing system in the local authority hospitals, however, had developed on different lines. Medical men entered the service of local authority hospitals before the war as a lifelong career of whole-time salaried medical officers. The summit of their career was to become the medical superintendent of a hospital, and remuneration was comparatively modest but the life had a sheltered character about it which was an attraction to a certain type of medical man. There had been a tendency before the war for a consultant element to enter into these local authority hospitals. Under some of them men of consultant training and qualifications would be employed on a whole-time basis. In others noticeably, for example, the largest of all, the London County Council hospital service, the consultant was employed on a sessional or part-time basis and as often as not literally used only as a consultant, that is to say, his opinion would be sought on difficult cases but he would not be asked to assume any particular responsibility for them. The staffing of these hospitals was of a comparatively simple character with a medical superintendent at the head and a hierarchy of salaried assistants beneath him, usually the minimum number by which the hospital could be run. In general, this produced a utility standard of hospital work, although there was an undoubted tendency for steady improvement and, prior to 1948, some major local authorities had attained an impressively high standard of efficiency.

30. Preparatory studies for the inauguration of the National Health Service led the authorities to adopt in the staffing of hospitals in the National Health Service the alternative system found in consultant staffed voluntary hospitals, both teaching and non-teaching, of before the war.

31. With the passage of the National Health Service Act of 1946 and the preparations for the N.H.S., by agreement with the medical profession the Ministry of Health set up an Interdepartmental Committee on the Remuneration of General Practitioners, the so-called Spens Committee, which reported in May, 1946. This report is not relevant to a background statement applying to hospital medical staffs, except that it became apparent to the medical profession as well as to the Ministry of Health that a similar study was needed upon the remuneration of consultants and specialists in a forthcoming National Health Service and this later committee, the Spens Committee for Consultants and Specialists, also under the chairmanship of Sir Will Spens, reported in May, 1948.

32. Certain principles of fundamental importance emerged from the work of this second Interdepartmental Committee. The Committee decided to take into account the past remuneration of consultants and specialists from all sources including private practice, and from any particular appointments that some of them may have held.

33. As is well known their recommendations were framed in terms of the 1939 value of money and the phraseology of the report has led to subsequent unresolved differences of opinion and interpretation between successive Governments and the medical profession as to methods whereby adjustments in income should be made in relation to altered values of money.

34. Another very important principle emerged from the study by the Consultant Spens Committee of the remuneration of the poorly paid preliminary training grades of hospital junior staff. The Royal Commission will observe that the Spens Committee found that even in non-resident posts members of the intermediate grade, carrying high responsibilities in hospital, received only £300 or £400 or even less per annum.

35. The Committee assumed, and this point of principle has been maintained ever since, that once a doctor attained a consultant post in the hospital service he would enjoy security of tenure, comparable with that enjoyed before the war in voluntary hospitals, and terminating only after retirement upon a suitable pension. This principle of security of tenure has been strengthened and protected since 1948 as a result of discussions between the Ministry of Health and the Joint Consultants Committee so that machinery now exists for the offering to a consultant of alternative employment if, owing to some sort of redundancy at one hospital, he loses part or whole of his employment. Also, appeal machinery exists which a consultant or a senior hospital medical officer can invoke if his appointment is reduced or terminated through no fault of his own or if he thinks that it is being unfairly terminated.

36. The decision was made by the Spens Committee to recommend equality of status as between consultants in different specialties and not to complicate matters by trying to have more than one grade of consultant. There has been no serious feeling in the medical profession since 1948 that this principle should be modified.

37. The Spens Committee took note of the widespread feeling in the medical profession and at Government level that one of the effects of the National Health Service should be to spread a more uniform level of hospital and consultant service throughout the whole country. Before the war the spread had been uneven and inadequate owing to the inability of consultants to earn an adequate living in the more sparsely populated districts and also in many urban centres. There was clearly a strong hope amongst all the authorities concerned, including the Spens Committee, that there should be a close liaison and linkage between the different types of hospital and between teaching and non-teaching hospitals throughout the country to facilitate its spread.

38. Another very important principle that the Spens Committee enunciated was that it was not really in the public interest or in the interest of medicine that a high percentage of future consultants should have to pass through a period of hardship and poverty before they succeeded in building up adequate private practices and it also declared that an adequate remuneration should be paid to holders of intermediate grade appointments during their period of training. The Spens Committee described various grades of registrar and house officer which have been accepted by the profession and by the Ministry of Health ever since they were first described.

39. The various levels of remuneration were also accepted in the same way. All the detailed recommendations for the remuneration of consultants were also accepted by both the Ministry of Health and the medical profession, including the period of time over which the consultant would rise to his maximum salary.

40. It is important to recognize that a part-time consultant cannot divest himself of responsibility in his hospital during periods of the week when he is not normally working in the hospital. For this reason the so-called system of weighting payments recommended in the Spens report has been accepted ever since the beginning of the Service.

41. Previous experience with some local authority hospital services made the medical profession (and probably the Ministry of Health also) aware of one of the dangers of a salaried service—be it part-time or whole-time—that a spirit of mediocrity might arise if increases in salary are based on seniority alone. Consultants therefore welcomed the recommendation of the Spens Committee on the principle of merit awards. These awards act as an incentive and a recognition of improving standards of professional work and efficiency and are allotted by a committee of authoritative character which takes into account all facets of the consultant's work and attainment.

42. The payment for teaching both undergraduate and post-graduate students as an additional factor of remuneration to that of the basic salary has been fully accepted since 1948.

43. The superannuation scheme has had no serious criticisms.

44. After the Danckwerts award to General Practitioners in 1952, consultants, who had refrained from making any earlier parallel claim, lodged a claim, through Committee B of the Medical Whitley Council, for overall increased remuneration on the basis of reduced value of money. After many direct discussions with the Ministry of Health of that day an *ad hoc* agreement was eventually reached whereby consultants received a modest increase in remuneration for the purely practical purposes as defined by the Ministry of Health, (a) of partially restoring the balance between consultants and general practitioners following upon the Danckwerts award, and (b) of safeguarding recruitment to consultant ranks. The Ministry declined to agree to any increase of consultant remuneration for the purpose of implementing more appropriately the "betterment" provisions of the Spens Report, but admitted in the case of junior medical staff the need to increase salaries to meet the rise in the cost of living. The agreement was a compromise and there was much in it which consultants did not greatly favour; for example, an increase in board and lodging deductions for house officers and some relative sacrifice by the highest paid consultants. This agreement, never looked upon as other than interim by consultants, was subsequently ratified in Committee B of the Medical Whitley Council.

45. There have, however, been considerable criticisms voiced since 1948 upon the factor of expenses allowable to consultants, both part-time and whole-time, incurred in carrying out their hospital work. The authorities in this case (correctly speaking they are the Management Side of Committee B of the Medical Whitley Council, but it

is felt that the Ministry of Health and perhaps the Treasury bear most real responsibility) have been unduly narrow in their interpretation of the relevant recommendations of the Spens Committee concerning these allowances, and it is considered by both part-time and whole-time consultants that the recommendations of the Spens Committee under this heading have never been met with equity. The part-time consultants' travelling expenses, on the whole, have been reasonably handled but there has been evidence recently of attempts by the authorities to restrict allowances and these issues are still sub judice in the Whitley machine. The allowance of expenses to whole-time and part-time consultants for study leave, which is essential to the maintenance of high consultant efficiency, has, in many instances, been denied or given grudgingly, particularly in the non-teaching hospitals where it is most needed, and there has been little or no allotment for expenses in the preparation of scientific papers, subscriptions to professional societies, and so forth.

46. The whole-time consultant feels a particular grievance in this regard as under Schedule E income tax regulations he has succeeded in obtaining very little of what he regards as legitimate expenses allowed free of tax. It is often essential for the whole-time consultant to use his car for his hospital work and he does not get adequate income tax relief on this point. It is noted that the Royal Commission on Taxation of Profits and Income has suggested a certain liberalization of the conditions of Schedule E and it is to be hoped that this will be brought about as soon as possible for whole-time medical men in the hospital service.

47. After the Service had been in existence for seven years consultants were disquieted by a sudden decision of the Inland Revenue authorities to place a large number of part-time consultants on Schedule E as far as their hospital earnings are concerned. An appeal to the Special Commissioners of Income Tax on this point has been won by the medical profession. The Special Commissioners declared that the holding of remunerated hospital posts by a part-time consultant, even a maximum part-time consultant, should be regarded as incidental to the practising of a profession. The Inland Revenue authorities gave notice of appeal against this decision, and it is to be hoped that this matter will be resolved as soon as possible and not left in suspense. It is a firm belief of consultants that it is in the public interest that the holding of hospital posts should be looked upon as part of the practice of our profession and consultants sincerely believe that the preservation of their status as highly qualified professional men practising a profession and carrying all the responsibility for the work that they do is in the ultimate best interests of medicine and society. They have no wish to divest themselves of any of the responsibility for their professional work nor would they willingly accept this. It is to be hoped that the Royal Commission will endorse the wisdom of this attitude.

48. It can finally be said in summing up about the Report of the Interdepartmental Committee on the Remuneration of Consultants and Specialists, that it has stood well the test of time and experience since 1948. There is no desire by consultants as a whole to-day to suggest that there should be any qualitative modification in any of these recommendations whatsoever.

49. The Consultant Spens Report was accepted by consultants and by the Ministry of Health and translated into the Terms and Conditions of Service for Hospital Medical and Dental Staffs. These Terms and Conditions of Service crossed the "t's" and dotted the "i's" of the Consultant Spens Report and translated its recommendations into terms of service suitable for a National Health Service beginning in 1948. It was, of course, considered at the time that the recommendations of the Spens Committee that adequate allowance for the altered value of money should be injected into post-war terms of service had never been carried out and it was expected that they would later be implemented.

50. The betterment factor in consultant remuneration amounted to only approximately 20 per cent. Nevertheless, in spite of this, after resolute negotiations lasting for some months, these terms of service were accepted by consultants and took the form at that stage of what were known as permanent contracts which were then signed by the consultant concerned and his hospital authority.

51. In these terms and conditions of service will be seen the description of one or two grades of medical officer not mentioned in the Spens Report, particularly those in paragraph 2 of the Terms and Conditions of Service. There remains still a problem

in the service concerning the position particularly of the so-called senior hospital medical officer. This post was created in order that a number of transferred officers who were clearly not of consultant status could be embodied in the National Health Service. The grade has persisted since under the terms of a circular agreed with the Ministry of Health in certain special departments of medicine. There have been disputes about the remuneration of this grade and arbitration has taken place. Many officers working in this grade repeatedly express discontent. Negotiation as to the future of this type of grade is being carried out with the Ministry of Health.

52. There has been a tendency since 1948 for most consultants to approach maximum part-time contracts, that is to say nine half-days per week.

53. Evidence before the Guillebaud Committee strongly supported the benefits of a part-time service as distinct from a whole-time salaried one. This still remains very firmly the opinion of the consultant profession. It is not merely a matter of financial advantage. There can be no doubt that the element of professional freedom given by being part-time greatly increases the sense of professional incentive and efficiency and the independence of the individual consultant.

54. It is strongly to be emphasized that consultants wish no material changes of principle at all to be made in the present terms and conditions of service which, as stated above, like the principles of the Spens Report, have stood well the test of experience.

55. What is needed, if we continue to live in an age of altering values of money, is some means whereby overall quantitative modifications in remuneration can take place smoothly, readily and equitably without any qualitative disturbances so that a stable standard of living can be relied upon. It is in the public interest that there should be machinery to maintain consultant's remuneration at all times at a level consistent with their professional status and responsibility. The Joint Consultants Committee believes that it would not be in the interests of the service if any processes of levelling down from the top entered into remuneration. It is most desirable that there should continue to be a small percentage of men whose very high ability and attainments are reflected in a high order of remuneration. Consultants regard this as essential in maintaining the position of the top levels of the medical profession in relation to the other professions and occupations in society. The Joint Committee, therefore, would oppose any modifications in remuneration which had the effect of leaving the top and senior levels more or less stationary in remuneration whilst those of lower levels were substantially increased.

56. The Joint Consultants Committee continues to press the claim made by the profession as a whole for a quantitative increase in medical remuneration as a result of the diminished value of money since 1951 and is a party to the arguments supporting this claim which were recently submitted to the Minister of Health and Secretary of State for Scotland.

57. The documents containing these arguments are attached as an appendix.

58. The Joint Consultants Committee is highly critical of the recommendations affecting the reorganization of medical services put forward in the Report of the Committee of Enquiry into the Cost of the National Health Service of January, 1956; for example, of the recommendations of this committee that a so-called new specialist grade should be introduced. It is discussing this at the moment with the Ministry of Health but it would regard such a grade as reducing hospital efficiency and likely to result in abuse by underpayment for medical service.

59. Consultants feel that more organized medical consultative and advisory machinery should systematically be introduced into the hospital service. Consultants gave evidence before the Select Committee on Estimates in the Parliamentary session 1950-51 on the Administration of Regional Hospital Boards and Hospital Management Committees and entirely agree with the findings of this Select Committee on Estimates that the Whitley Councils in the National Health Service have not worked as efficiently as they should. We would like to quote to the Royal Commission the phrase from the report of the Select Committee on Estimates in paragraph 29:

"The efficient working of the Whitley Councils is of the highest importance not only to the service but also to the national economy. Your committee are not satisfied that the councils work efficiently."

60. Consultants believe that there are two main problems of remuneration affecting hospital medical staffing at the present time. One is the fixing of the overall quantitative level of remuneration at an equitable level based on the Terms and Conditions of Service and in relation to the present diminished value of money. The second of the main remuneration problems is the efficient, almost day to day negotiation of small details of remuneration that appear constantly to be turning up, such as: what should be the remuneration of clinical assistants in the hospital service? What improvements or modifications should be made in the board and lodging charges for resident medical staffs? What conditions should be laid down for their standards of accommodation?

61. It is necessary to have some form of appeal machinery to which individual members of hospital medical staffs can apply if they feel that the terms of service are being wrongly interpreted and applied to them. Some machinery must exist for the "bread and butter" type of negotiation on remuneration. This may well be the Whitley Committee, but consultants feel strongly that the inelasticity and slowness of this machine has caused considerable irritation to both management and staff sides.

62. The Royal Commission may feel that a new form of machine should be devised or the existing arrangements improved. Under the existing Whitley machinery neither side can go to arbitration without the permission of the other. In other fields many bodies in dispute with their employing authorities have the right, under the Industrial Disputes Order, to go to arbitration unilaterally.

63. This right might very well hasten and improve the day-to-day Whitley negotiations for hospital medical staffs.

64. When the Terms and Conditions of Service were finally agreed in 1949, the Permanent Secretary of the Ministry gave an undertaking on behalf of the Minister in the following terms:

(1) no changes would be made in the terms and conditions of service without discussion in the appropriate part of the Whitley machinery when established, and this would be established as soon as possible;

(2) remuneration was regarded as a subject suitable for arbitration;

(3) save in exceptional circumstances, and after the conciliation machinery of Whitley had been exhausted, issues of remuneration remaining in dispute would go either to arbitration or for enquiry and report by a committee.

In practice, since 1949 these clauses have been inconsistently and inadequately applied. Their spirit has rarely been honoured by the authorities.

65. In regard to the quantitative overall modification of the hospital medical staff remuneration the Joint Consultants Committee welcomes the third term of reference of the Royal Commission and hopes very much that the Royal Commission will find its way to recommend some form of high-level review organization for this purpose.

66. Finally, it should be said that consultants do not propose any material modifications at the present time in the administrative structure of the hospital service and its division into Boards of Governors, Regional Hospital Boards and Hospital Management Committees. Except in the case of hospitals especially designed for general practitioners, such as cottage hospitals, consultants believe that hospitals should uniformly be staffed in the long-established way of the consultant staffed voluntary hospitals before the war, that is to say by beds, patients and departments being in the care of an adequate staff of physicians, surgeons, and other specialists of consultant status.

67. It is the hope of consultants that the Terms and Conditions of Service and the level of remuneration will be such that the steady process of up-grading of the country's hospitals will continue. They desire to see the high standards of British teaching hospitals fully maintained and the standards of non-teaching hospitals gradually and steadily elevated as has in fact been the case since 1948.

68. Consultants believe that with somewhat improved administrative machinery it should be possible actually to improve the consultant staffing of many hospitals of this country without greatly increasing the overall costs.

69. They support improving liaison with general practitioners and public health services by liaison sub-committees where appropriate.

September, 1957.

Note:

The documents contained in the Appendix to this memorandum have already been published in the *British Medical Journal*.

Remuneration of General Practitioners and Hospital Medical Staff. Case submitted to the Ministers by the Profession.

Supplement. 1956. July 28th. pp. 75-83.

A Supplement to the Outline of the Case.

Supplement. 1956. November 3rd. pp. 173-177.

Examination of Witnesses

SIR RUSSELL BRAIN

MR. T. HOLMES SELLORS

DR. J. D. S. CAMERON

DR. T. ROWLAND HILL

on behalf of the Joint Consultants' Committee.

Called and Examined

291. *Chairman:* We have read your very interesting memorandum, which we much appreciate, and you are here in reply to our request for a little background information. I understand you are expecting to put in some more evidence on some of the main matters of interest to you and to us shortly, and that you do not want to deal with all the questions now which may be more fully covered in your later memorandum?

—*Sir Russell Brain:* Yes, thank you. We hope our memorandum will be in your hands in two or three weeks time.

292. I feel quite sure we will have some other questions which need answering arising out of your second memorandum; but meanwhile I hope you will feel free to say, if you wish, that you would prefer not to answer some of our questions until later on.—Thank you very much.

293. We have received evidence from a great many bodies; and therefore we have appointed sub-committees to consider the kind of questions we want to ask our witnesses. In this particular case Sir David Hughes Parry is chairman of the sub-committee that has done most of the work, so he will probably be asking most of the main questions.

But in due course probably every member of the Royal Commission will want to ask something on some of these problems.

First of all, Sir Russell, would you like to tell us just exactly whom the Joint Consultants Committee represent and what is, as it were, the coverage of the COMMITTEE?—The Joint Consultants Committee consists of representatives of the Royal College of Physicians of London, the Royal College of Surgeons of England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the Royal Faculty of Physicians and Surgeons of Glasgow, together with six representatives of the Central Consultants and Specialists Committee, which is a committee related to the British Medical Association. Altogether we have about 18 or 19 members, and we are concerned with the medical staffing of the hospital service—the hospital branch of the health service.

294. Am I right in thinking that you also cover the dentists to the extent that they are dental consultants?—We have had a dental observer who has attended our meetings up to now. In general the

terms of service for dental consultants are the same as for medical, and we are just reaching a stage at which we have asked our dental colleagues to send two members who will be members and not merely observers in future.

295. I understand they associate themselves with your main submission?—Yes, entirely.

296. So indirectly are all consultants in the United Kingdom represented through the members of your committee?—Yes, except for the very few who may not have contracts with the Health Service; but all consultants and all members of medical staff of hospitals down to the house officer and house surgeon are represented by this committee.

297. *Sir David Hughes Parry*: I think the first matter the Commission would like to cover with you is the question of the recruitment and the attraction of students, their maintenance during training, the length of their training, and things of that nature. I shall try and keep to—those are my instructions—what you have already raised in your memorandum, knowing of course that you are going to submit another memorandum. In your first paragraph you refer to the fact that nearly seventy per cent. of medical students are in receipt of grants, and in the last sentence you refer to the vocational aspect of the choice of students of a medical career. We would like to know what you mean to include in the expression "the vocational aspect", because you indicate that it is tempered by various other considerations.—I think what we had in mind was, looking at the picture broadly and in the light of the past, that in the past many sons of doctors went into medicine to follow the profession of their fathers. The financial position in the past meant that most people, if their parents could not afford to pay the major part of their fees, and unless they won scholarships, could not enter medicine. The existence of large educational grants has changed the position very materially, and there is no longer the same financial handicap that used to exist. It is difficult, I think, to say how far the situation has changed in respect of such things as family tradition—that is a thing about which views rather differ—but broadly the effect of educational grants on a large scale has been to widen the social stratification of

medicine, and probably relatively to diminish some of the older incentives and family traditions, naturally enough. I think that is mainly what we had in mind. It must of course also be influenced by what appear to be from time to time the financial attractions not only of medicine as a whole, but of particular branches of it.

298. Do you think that the grants as they are today enable a student to maintain himself from beginning to end of his training?—We had notice that we were going to be asked some questions about this, and I think I should say I know that the Royal College of Physicians has gone into this very fully and has collected a good deal of information and actual figures; and while we have not collected that information I do not know whether you would feel that on the question of the actual figures it would be better to leave the Royal College of Physicians to deal with this point.

299. We would like to get information to see whether the grants as they are at the present time do sufficiently maintain a person from beginning to end of his career as a student.—Well, I know the College has precise answers to that, has estimates for the cost of the total career, and deals with such things as clothing, lodging allowances; they have all the figures.

300. Thank you. Do you think that the absence of maintenance grants for persons at a particular grade of income is hindering the sons of doctors from going in as students?—I think we have no doubt that that is the case, that the imposition of what seems to us rather an arbitrary limit means that a doctor who has possibly four sons may not be able to send as many as he would wish—or as they would wish—into medicine, because the limit restricts their qualification for scholarships and grants.

301. I wonder if you could give us some concrete evidence of that. We would like to get some concrete evidence in support of what you have indicated.—That again is a matter on which I know the College has evidence which it is going to bring. Our evidence is based on our personal knowledge of individual cases. I do not know whether any of my colleagues here have anything

to add.—*Mr. T. Holmes Sellers*: I think it must be entirely on individual experience so far as our figures can go.

302. *Mr. Bonham-Carter*: Sir Russell, in this connection have you any opinion—I am not pressing you on facts at this stage in view of what you have said—as to the time in a young man's career when a decision relating to this aspect of affairs is taken? If I may explain the point behind my question, it is this. I have in another field raised this particular subject with another Ministry—not the Ministry of Health at all—and their answer has always been that they have no evidence that people do not in fact go to the university—which is what we are talking about really in my case—because of financial stress as a result of this means test. But I have always suspected that when you ask a young man of 19 or 20 it is irrelevant, he had to take the decision much earlier in life—or his parents did. Does your own experience help in that direction at all?—*Sir Russell Brain*: I should have thought the decision is usually taken at about 16 when the boy or girl at school has to specialise for a career, and that is what determines the decision. But I would have thought that financial considerations in the parents' minds are surely just as powerfully operative then as later.

303. In fact that decision would have to be taken at about the age of 16 for the medical profession?—Yes.

304. *Sir David Hughes Parry*: I understood you to say that students now are drawn from a much wider social class than formerly?—Yes.

305. Many of those who thought they had a vocation before this period were not able to train as medical students, were they?—That is quite true.

306. Therefore there ought to be a bigger number really who feel that they have a vocation for the profession now going in as students. That ought to follow, ought it not?—I think it does follow. I do not think we wanted to imply the contrary of that.

307. That makes clear, I think, the point which was rather doubtful in my mind.—Perhaps our last sentence might have been amplified a little.

308. The other matter is in paragraph 4. You say here that you have received "prima facie evidence from various authoritative quarters that schoolboys of the highest ability are not those most commonly drawn towards a medical career today and that the intrinsic ability of the average medical student is not as high as it might be." I really ought to have asked whether you think the attractions before the National Health Service were sufficient to draw men of the very highest ability, or a great number of people of the highest ability, and has there been a lowering since then?—I should have thought it is very difficult to be dogmatic about this, and it is something about which it is very hard to obtain reliable statistical evidence. What we had in mind here was the impression we have got mainly from talking to headmasters and science masters at schools, who are apt to say that they think that by and large, boys entering other professions, or more, shall I say, academic careers, tend to be of a rather higher standard than those entering medicine. But I do not think any of us would be prepared to lay great stress on that either as a fact today or in comparison with the past, because I do not think we have any very reliable data: it is just an impression, and I would not put it any higher than that.

309. But you agree that the professions generally are more open now to attract students, and that therefore the competition between the professions is very much greater?—Yes, indeed; I think that follows really from what we have been saying about the effect of grants throughout the whole of professional life.

310. You have not got anything in the form of statistics, but simply a general impression of that?—Only a general impression. I think statistics might conceivably be based upon the academic attainments of those entering medicine compared with others in their various qualifying examinations, but I should have thought it would be very laborious to get and I doubt if it would be of much value.

311. *Chairman*: You say there that some are of the opinion that the intrinsic ability of the average medical student is not as high as it might be. But from the rather uncertain tone of that paragraph

do I take it that this is not something that is causing particular concern?—No.

312. *Sir Hugh Watson*: We have before us a memorandum prepared by the Royal College of Physicians of Edinburgh, which comes down very slightly on the other side of the fence: "So far as the quality of the newly-qualified doctors is concerned the committee has the impression that the present medical graduate compares favourably with his pre-war counterpart, though it cannot support this opinion with any objective evidence." Do you agree with that?—I think it is difficult to rely on impressions, especially as one gets older and looks at the past. I would not say I have noticed any substantial difference one way or the other.

313. *Chairman*: It would look as though in these two submissions of evidence we have had, one has come down slightly on one side and one on the other; is that it?—Yes.

314. *Sir David Hughes Parry*: In paragraph 2—the method of training—you draw attention to the fact that it takes six or seven years' training. That is a longer period than most professions, but not all. Take the profession of solicitor, generally a longer period is involved there, is it not, if he took a university degree?—In general it is, yes.

315. But now seventy per cent. would be maintained throughout that period. You suggest later on that there should be another year—and they have an intern year after that, do they not?—and that would make it really seven years; and in paragraph 5 you suggest the addition of yet another year of intern service, do you not?—Well, this is not another year. What we are really describing is the existing practice, and particularly the past practice. It has always been thought desirable that a man when he has qualified, having done one year of house appointments, which he now has to do, should go on and do at least another one. That was, I think, more the practice in the past than it is today, when for various reasons many young men are anxious to get established and tend to leave the hospital after one year in order to go into general practice particularly. We feel that they would be better doctors if they did at least another year as well as their compulsory provisional registration year.

316. But it would make the period of training very long if this became general, would it not?—It has been general; it is not really anything new. I think it has in the past been very widely done. We would think it desirable.—*Dr. Cameron*: I think we might answer that the one year might be taken as part replacement of the two years at present spent on national service. We were looking towards a disappearance of the two years of national service, and one of those two years then being employed for further hospital appointments.—*Dr. Hill*: There is just one point I want to make here, and that is this: that we hope under the National Health Service junior hospital appointments will be sufficiently well paid to make them be looked upon as part of a young doctor's career rather than his training. You see, medicine today has grown more complicated, and just as a young naval officer has to work so many years at sea and so many years ashore, one should look upon these years of a young doctor in hospital, if he is properly paid for them, as part of his career rather than part of his training.

317. *Chairman*: Would you consider that in fact it would be desirable for more than one year to be compulsory?—*Sir Russell Brain*: No, I do not think there should be more than one compulsory year.

318. You feel it should be sufficiently in balance as far as earnings go with other branches to make it happen very often—not to involve financial sacrifice to stay on. That is your point?—Yes.

319. *Mr. Bonham-Carter*: Dr. Hill has answered the first question I wanted to put, but what sort of age group are we talking about now; what age roughly are the men in this first and second year?—About 24.

320. They are 24-26?—Yes.

321. *Sir David Hughes Parry*: That, I think, covers the points that we wanted to raise on the attraction of students and their training, and I am quite satisfied now. I was not quite sure from paragraph 5 whether you had any contemplation of a two-year compulsory period?—No.

322. Now could we turn to the attraction and training and maintenance of registrars, and the payment of registrars?

You lay great emphasis there on the competitive hospital training of registrars, do you not? I am not quite sure what you mean by the word "competitive" there. Paragraph 5: "A very much longer period of competitive hospital training is needed for the young doctor who hopes to become a consultant." I am not quite certain what is meant by "competitive training".—That means that he goes on from post to post in competition with others, and therefore there is selection at this stage of the best people, because the others fall by the way.

323. And you think that that is a necessary element and a vital element in the training for the consultant stage?—Yes, it is the traditional method which has been adopted for many years, and it is really implied by the fact that as one goes up the scale there are fewer posts and therefore there must be more competition.

324. *Chairman*: Have you any broad idea, Sir Russell, on this question of competition as to what sort of proportion of those who would have liked to become consultants should fall by the way in order to get the best people; or how many do, if you like?—*Mr. Sellers*: I think at the registrar level a great many of the young doctors have not yet decided what branch or specialty they want to go into, or even if they are feeling their way and getting a wider education as doctors, and it may be that one of those particular branches will be the one they will choose to try and enter. From that point then the competition becomes a little more selective and narrowed down. I think at the present moment when we come into the senior registrar grade we are more or less agreed that the ideal state of affairs should be a wastage of about 10 per cent.—that is, from illness, from people who are just not up to the standard and do not make the training grade, and for various other reasons. There ought to be some percentage of wastage when you get to the final step in training. But until you come to the senior registrar grade they are not in active training for a given specialty in medicine—they may be on their way, but at the registrar level they can still switch into any other branch or into general practice or public health, or whatever they may want.

325. *Sir David Hughes Parry*: You are in effect saying that up to the end of the period of training as registrar they ought to be fluid—they can go in any direction?—Yes. They may start from the very beginning at what they are aiming for, but they can change.

326. What I call the diversion should take place at the end of the ordinary registrar stage; that is normally the time of diversion into general practice or into the consultant grade. Is that right?—*Sir Russell Brain*: Yes, and after they have been accepted as senior registrars one would hope there would be very little wastage if they have been well selected and are sure of their own minds.

327. *Chairman*: Competition can be partly a question of speed, of how long you spend in each grade, as well as a question of whether you fail or succeed altogether. That is partly what you mean by competition?—To a limited extent, yes.

328. *Sir David Hughes Parry*: What sort of period do you expect the registrar period to cover—how many years?—The ordinary registrar period would normally be about two years.

329. *Sir Hugh Watson*: Before he becomes a senior registrar?—Yes, or goes into some other branch of practice.

330. *Sir David Hughes Parry*: Is that normal now, or is it longer?—It is normal now. If he has done a compulsory year as house appointments, then another year, two years as registrar and four years as senior registrar, then that is eight years after his qualifying examination already.

331. Many of those who have served as registrars would like to become senior registrars no doubt, would they not, but have failed in the competition to make the grade; is that right?—Yes, it is true; I cannot say how many, but it is true.

332. Then where will they be diverted?—Some will go into general practice.

333. *Sir Hugh Watson*: Up to what stage do you find that people do in fact go into general practice from the hospital service?—That is a very difficult question at the moment, which we are much concerned with. It is at present for various reasons very difficult for men who spend long in hospitals in the more senior posts to get into general

practice, and that is one reason, I think, why those who go into general practice go in as quickly as they can.

334. Which is probably not a good thing for the profession. You would prefer them to stay in hospitals longer?—Yes.

335. *Chairman*: Is the line between general practice and hospital service much more clearly defined than it was before the war?—Yes, much more. In the past the fact that a man had had long hospital experience and perhaps some higher qualifications was an asset to him very often in general practice, but that seems to be no longer the case.

336. *Mrs. Baxter*: And is this in your view due to the fact of the increasing complexity of medicine, the increasing specialisation required in the senior registrar's post?—I think it is due to a number of facts. That is undoubtedly one, because a man who has had a highly specialised post as senior registrar is obviously difficult to fit into general practice. But there are other factors—the fact that in the past a man in general practice often held hospital appointments and therefore his specialised knowledge was of value to him still. And there are certain other factors concerned with general practice, which we are not in fact concerned with, which influence the intake of men who spend time in hospitals.

337. *Sir David Hughes Parry*: Can I move on to the stage of the senior registrar? How many years at the present moment do they spend in this particular stage?—It was contemplated that they would spend four years normally, but owing to present conditions many senior registrars are not able to obtain consultant posts, and there are quite a few who have been in senior registrar posts for as long as seven or even eight years.

338. I think you state in paragraph 15: "The Joint Committee agrees with the recommendations of the Spens Committee that the average age for achieving consultant status should be 32 years." It is not quite average, is it? It is the normal age rather than the average age, because very, very few get there before 32. They are mostly well after 32, are they not?—*Chairman*: What in fact is the earliest age at which a person could achieve full consultant status?—

There have been some at 31, I think. Perhaps we have used the wrong word there. The age at which a man could normally hope to be able to become a consultant was 32, or a little younger even. That was the figure which the Spens Committee adopted in the light of previous experience. We did have notice of a question relating to the past on this topic.—*Dr. Hill*: There is nothing to prevent a man applying for a consultant post before the age of 32, and if he has the qualifications he may win that post. He may win it when he has perhaps done only one year as a senior registrar. He is not compelled to wait until he has done four years before he applies. So you have today the rather anomalous position where in certain branches of medicine a man is quite often appointed a consultant at an early stage in, for example, anaesthetics or mental hospitals, whereas in acute medicine or surgery it is today, unfortunately—and we are concerned about this—quite often very much later, maybe at the age of forty.

339. *Sir David Hughes Parry*: At what age did they attain consultant status before the war?—*Mr. Sellers*: The impression amongst ourselves was that in acute medicine and surgery it was at an average a good deal younger. I think most of us here attained consultant status at or before the age of 30.—*Sir Russell Brain*: Yes, that was generally so. In those days it was not uncommon for a man who still held a part-time registrar appointment in one hospital to become a consultant at that time in perhaps one or two smaller hospitals.

340. There were two grades of consultant at that time, were there not?—There was no grading.

341. Two categories?—I am not sure what you have in mind.

342. Was there not a senior and a less senior?—No. There were of course senior physicians and assistant physicians or senior surgeons and assistant surgeons in hospitals, but they were all consultants of equal status and qualification. It was merely a differentiation usually of the number of beds they had and the amount of time devoted to outpatients and things of that sort. But there was no differentiation of categories between them.—*Dr. Hill*: It is most important that there should be no misunderstanding over that. You will find it defined in the Spens

Report where one of the paragraphs specifically referred to the assistant physician or assistant surgeon. He was a full consultant of the same status as his senior colleague; but he was younger, and in the course of the passage of time he became a senior. But today the phrase is sometimes loosely used to define a grade which, certainly fortunately in our opinion, never came into existence in our hospitals service, namely a lower grade than that of the full consultant.

343. *Professor Jewkes*: I just wanted to ask at this stage if we leave on one side quality, where clearly opinions differ, is it your view that there is a shortage of consultants now?—*Sir Russell Brain*: Oh, indeed, yes!

344. That is to say, there would be an advantage if the establishment, as it were, were enlarged?—We have been urging that for some years. There is a great deal of evidence for that. In some specialties there are parts of the country where there is no specialist of a certain kind available; there are long waiting lists of outpatients to be seen; and there is evidence that a considerable part of major surgery is being done by senior registrars of long experience, whom we feel should be by now consultants and who are doing the work of consultants.

345. How do things begin so that an establishment can be increased, *Sir Russell*; what has to happen?—There are various ways, but primarily the REGIONAL HOSPITAL BOARD, we would hope on the advice of its medical advisory committee, would say: "We feel that we need x more consultants in these spheres." It would then apply to the Ministry of Health, where the matter would be considered by a special sub-committee, where there is medical representation; and if they agreed then steps would be taken to advertise the posts, always provided that the REGIONAL HOSPITAL BOARD has the money to pay for them. But of course it has to consider its finances in the light of other claims related to all its other activities, and not purely the needs of the consultant service.

346. So both in the interests of efficiency of the service, and in the interests of equity towards the senior registrars who should be promoted, you are quite clear that it would be desirable to have more consultants?—Yes.

347. I may have rather misinterpreted the Willink Report, but on the whole I got the impression that they do not express very much anxiety about numbers, and they thought perhaps at the moment there were as many doctors as we needed in the country. Is that a correct interpretation of the Willink Report—or perhaps you do not read the Willink Report in that sense?—I cannot remember what they said about the precise numbers. It is a very difficult question as to how many doctors there should be.—*Mr. Sellors*: I think one point is that there is a great deal of consultant work that rightly ought to be done, and is not being done by consultants, at the present time.—*Mr. Cameron*: And I would add that that probably applies to certain parts of the country more than others.

348. *Chairman*: Certain specialties also?—Certain specialties and also certain hospital areas. The tendency is to make do with senior registrars.

349. *Mr. Gunlake*: Does that mean that the REGIONAL HOSPITAL BOARDS have in very different ways in carrying out this task?—*Dr. Hill*: Perhaps I might answer that as a member of a REGIONAL HOSPITAL BOARD, I should say they do it in many different ways, and I think in no instance do they do it in a way that we as representative consultants would regard as satisfactory and efficient. It is undoubtedly more efficiently done by BOARDS OF GOVERNORS. We regard this as one of the most serious of the NATIONAL HEALTH SERVICE's problems today, and it applies particularly to the most important branches of medicine and surgery, acute medicine and surgery in hospitals; and it is in that field that today we know it is not a question of absolute shortage of manpower—it is using manpower wrongly. The number of general surgeons in our general hospitals throughout the country has hardly increased at all since 1948, an almost unbelievable state of affairs; but there has been an enormous increase in senior surgical registrars, and we know that a high percentage of those men are in fact doing work that before the war would have been done by a young consultant. It is a very serious position because their future is still quite uncertain although many of them are men in their middle thirties, married with families. It has undoubtedly been administrative tardiness, and prob-

ably some sort of rather blind financial restriction that has held back the expansion of consultants and allowed the work to be done, really consultant work, in these acute branches of medicine by men who are qualified to be consultants but who have been kept in a lower rank. It is rather like—for the sake of comparison—putting a commander in charge of a fleet instead of making him an admiral.

350. Is there no machinery by which the REGIONAL HOSPITAL BOARDS can collaborate in this matter? Do they each have their own individual ways?—*Sir Russell Brain*: I think that is a most important question, because clearly the consultant needs of the country should be kept in review for the country as a whole. On the other hand, a great deal of responsibility must devolve on the local regional boards which should have freedom in these matters. And I think we have fallen between two stools in the past—a tendency to inadequate central planning, and a desire to leave more to the periphery where the peripheral planning is affected by all sorts of financial considerations. We have felt in the past the machinery has not been altogether adequate.

351. *Professor Jewkes*: There seem to me to be two things that so far in my own mind I have had muddled up. It would be one thing to say a great amount of work that is really consultant work is done by the senior registrars and this is unfair and there should be methods for promoting the senior registrars; but it is quite another thing to say there is a shortage of people in total who can do real consultant work. Could I get this quite clear by asking you again, do you think there is a shortage of both consultants and senior registrars? Taking them together are there too few of these people who do consultant work, whatever they are called?—I think that there may still be scope for more appointments in certain fields, but by and large I think it would not be true to say there are too few consultants and senior registrars. If enough senior registrars were made consultants, broadly I think an adequate and reasonable service would be provided, allowing for certain exceptional fields where we could do with a few more.—*Dr. Hill*: One might add that, the Minister's advisory committee on which some of us sit shows that there are some branches of medicine which quite naturally attract the best men in medi-

cine. They usually wish to be either a physician or a surgeon dealing with acute medical or surgical disease. Looking after mental patients in a mental hospital, experience shows, is much less attractive. The same applies to a branch like radiology. It is true that there is at the moment a shortage of properly trained consultants in psychiatry in mental hospitals, so much so that the Ministry of Health in conjunction with representatives of this committee has had to ration the making of consultant posts in mental hospitals to prevent men who are not really of consultant status being put into such posts. On the other hand, the position is quite different in what we might call the most important or the most lifesaving branches of medicine and surgery, the restoration to health of the acutely ill. There, there are plenty of trained men available in the country today to occupy those consultant posts, but the tragic position is that it is in that field that the promotion is being held back. If you take a man today who is a senior registrar in general surgery doing advanced surgery, if he had taken up mental hospital work he would long ago have been a consultant.

352. I am still not certain on this point. Suppose you had a senior registrar who at the moment is doing consultant work and then he is promoted to a position as consultant and still continues to do consultant work, nothing has happened as regards the patients—the same quantity of work is being done. What happens then about the waiting lists? They will not be reduced if we just change the name of a man and he continues to do the same work.—*Mr. Sel'ors*: I think there are areas where there is a definite shortage of consultants where all the work is not being done by senior registrars and consultants. There is particularly in some of the peripheral hospitals an active shortage of people to do consultant work.

353. *Sir Hugh Watson*: There are two pictures being presented here. One is a shortage of consultants in certain areas: the other is something amounting to a frustration in registrars. Both of these things obviously concern this Royal Commission. Is it my understanding that this bottleneck is to a considerable extent temporary and due to temporary causes?—*Dr. Hill*: Yes, it is primarily due to the effects of . . . it is perhaps unjust to call it the "first, fine, careless

rapture", but the first step of expansionism after 1948, when new posts were created for registrars in large numbers, and everybody felt that this was going to be an expanding service in which the whole country would soon be covered by consultants, and the prospects for these registrars were very good. But I think it was about the year 1950 that the Ministry of Health suddenly seemed alarmed over this matter—I think on financial grounds—and started putting the brake on the creation of new consultant posts, and then took the drastic step of trying to ration the number of senior registrars to a certain figure, which only partly alleviated the problem; so we have today what some people call the bulge—a large number of fully trained registrars with no future and in excess of the demand, owing to the expansion of consultants being held back.—*Sir Russell Brain*: I think it is fair to say there have been increased numbers of consultant posts created every year, but our view is that it has not kept pace with the needs for these registrars to be appointed, nor altogether with the needs of the country.

354. *Chairman*: Do you envisage a more or less permanent balance among the number in general practice and the number in the hospital service, *Sir Russell*, or do you envisage a continuing trend to more consultancy and less general practice?—That is not a question I think we have yet considered, or at any rate have an answer on. I think we might leave that over for the present and perhaps deal with it on another occasion.

355. Because, realising that the statistics were a bit nebulous before the war, there has been, I think, a considerable trend towards the consultancy branch since the war, or is that again rather difficult to be sure about?—I think we would like to look into that. It may well be true, but I have not any evidence at hand. It is a complicated question, because it is obviously influenced by the enormous development of the technical side of medical science in hospitals which has occurred and is still occurring.—*Dr. Cameron*: Another point I think is that part of the development of the hospital service has been in the direction of providing a service in areas where it was never previously provided; that in the pre-Service days

you had to go to a city in order to obtain the services of a consultant, whereas with the Service we now have consultants available in all parts of the country. I think another point is the position of the so-called supernumerary senior registrars. They might give an indication as to the number of posts which are rightly considered to be consultants posts and which are filled by senior registrars. In Scotland they were called for a time the "x" posts and they were being reserved for the time when some change took place in the hospital staffing. There are a number of posts still so filled by supernumerary—as they are called—senior registrars who are really doing consultant work but still not being called consultants.

356. *Sir David Hughes Parry*: What you are really suggesting is that apart from the ten per cent. wastage there ought to be sufficient consultant physicians for all senior registrars to be, after a reasonable time, raised to that level; is that right?—Yes, at present. Then we should have to think in the light of future planning how many senior registrars was the right number to train to fill expected consultant vacancies.

357. I wonder whether 10 per cent. wastage is a reasonable figure. If you take the universities, the wastage there in the lectureship stage—it would correspond presumably with the registrar—is very much greater if you consider the professoriate corresponds to the consultant grade. Many lecturers do not reach the professoriate grade—much more than 10 per cent.—and I wonder whether 10 per cent. is not rather a small proportion of wastage?—*Mr. Sellers*: I think, if I am interpreting you correctly, our point is that the senior registrar automatically in the course of time, and if he is worth it, becomes a consultant. It is not like in the university stage where there are any number of lecturers and only one professor. There is a wide range of consultant posts for these people.

358. You used the expression "if he is worth it". You admit therefore that in the senior registrar grade there are many, or there are some . . . ?—Not many—a very few—whom we may have judged wrongly at the selection stage, or who did not live up to their original promise.

359. *Chairman*: That is this ten per cent. wastage? If people become consultants in their early thirties they presumably will be consultants for about thirty years?—Yes.

360. On the other hand registrars will presumably be registrars for something up to six years, junior and senior?—Yes.

361. So that one would assume that there will always be very many more consultants than registrars, something like five times as many; is that what you visualise?—Yes. And I was going to say the number of senior registrars on the establishment was originally calculated so that they might all, subject to a small wastage, become consultants, which is rather different than the ratio between lecturers and professors. That is why we would not expect there to be any substantial wastage later on, if our selection has been sound.—*Dr. Hill*: I think Sir David was looking at this question of wastage over too narrow a period. It should be looked at from house officer stage up to consultant. It is very heavy in the junior stages. There is many a house officer today who would have liked to be a surgeon, but he goes out before he becomes a registrar; so it is cumulative wastage over a period of six or eight years.

362. *Sr David Hughes Parry*: I wonder whether from your long experience in this matter you can gauge in two years whether a man is going to be a good consultant, because the period of service as a registrar, as you indicate, is two years?—I think two comments ought to be made on that. The gauging will begin earlier than the registrar stage. Promising young men will begin to be looked at in their house officer stages. Secondly, it is the case that hospital authorities can renew a registrar's post for a second period of two years, or more than that, if they wish to, and certainly in many non-teaching hospitals men are serving for a second period of two years. That has led to another serious position in non-teaching hospitals that I wanted to mention in particular; and that is that owing to the Ministry's rationing of senior registrars plus holding back or discouragement of consultant expansion, there has been during the last few years, particularly in REGIONAL BOARD hospitals, an increasing

amount of consultant work in both medicine and surgery carried out not by senior registrars but by registrars who have been re-appointed. For example, I was looking at the figures of a great hospital in Manchester, where a middle grade registrar, not a senior registrar, is a man with his F.R.C.S. of the Royal College of Surgeons, and he spends most of his time doing unsupervised major surgery and seeing outpatients.

363. *Chairman*: From the figures we have in the Ministry's factual memorandum there would appear to have been considerable expansion in the number of consultants, and at the same time a considerable fall in the number of senior registrars in the four years up to 1955, which suggests that what you desire as a tendency has been going on; is that right? There were 888 more consultants in 1955 than in 1951 and 285 fewer senior registrars.—*Sir Russell Brain*: I am afraid we have not got those figures. I do not think they have been published yet.

364. Yes.—We have not had that yet.

365. I think you probably had it before it was in this form (indicating the booklet) but this is published, price 5s. 6d., by the Stationery Office, and the details are on page 62.—Thank you. I think one answer to that is that the figures would have to be broken up, because different things have happened in different specialities. But up to a point I think it is true that there has been an increasing number of appointments made and that has absorbed some of the registrars; but it still remains true that in general medicine and surgery, for example, there is still a need for more consultant posts, and there are senior registrars available to hold them.

366. *Professor Jewkes*: And do I understand that in any case there has not been a large enough increase in consultants plus senior registrars over the period—that your committee would like to see an increase in the total quantity of consultant work that is being done?—In certain areas in certain fields, yes.

367. And since you are not suggesting a reduction in other areas you are really suggesting we should have an absolute increase?—Yes.

Chairman: Again I think we should say that there was an absolute increase

during those four years, and as far as one can judge quite a considerable one.

368. *Mrs. Baxter*: May I ask Sir Russell a question? I understand there were difficulties, and there are difficulties, in mental hospitals, for instance—it was one of the specialties to which you referred—that there are difficulties in filling consultant vacancies with men of sufficient calibre to be called consultants; is that right?—Yes.

369. Might I ask at what point, if at all, men and women at the moment of specialising get any advice or any encouragement towards specialising in the specialties which are known to be lacking in good people?—As far as I know I do not think there is any official machinery by which they could be given such advice; they might themselves seek advice.

370. This seems an internal matter that if there is all this over-production in the popular lines this would be a matter which the medical profession itself would handle.—There has been a tendency in recent years in view of this situation to try and encourage senior registrars to go into the specialties where there was a need. It has succeeded to some extent but their own personal likes and dislikes naturally come into this a good deal. There are other factors of course, particularly in the mental health sphere, which come into it.

371. *Chairman*: Is it partly a matter of looking far enough ahead and trying to see what the position will be say five or ten years after a decision to specialise in some particular thing?—I think that is partly it, and of course in the past I imagine that many people's decision was really based on chance. Having qualified in a general way, they found an opening in some department and they went into it and obtained certain posts there as a result of a chance opening.

372. *Mrs. Baxter*: That is the impression I had.—*Mr. Sellors*: There must be a good deal of opportunism in choosing the exact specialty. The number of people fanatically inclined to one specialty is not so large as those who are interested in a broad line.

373. *Sir Hugh Watson*: Is there a disinclination to go in for psychiatry or mental hospital work?—*Sir Russell Brain*: I think it is very hard to generalise about that because many more have

gone into it in recent years than in the past. But I think perhaps in some ways it does demand a strong sense of vocation, and there are other problems connected with it—the siting of mental hospitals and the need for modernisation of buildings, and administrative responsibilities. All sorts of factors operate in that field.—*Dr. Hill*: That is true, and I think it would be very unwise to underestimate the element of choice here. I have been very interested in the young men that have passed through my hands. I am sure many of them have had an ambition, for example, to become a consulting physician, but they would rather be a grocer than a consulting radiologist, or something like that. They are almost different professions. And they would change from a clinical branch to a non-clinical branch with the greatest reluctance.

374. *Chairman*: I think you have always considered as a profession that you do not want different grades of consultants by specialty, so to speak, at least as far as remuneration is concerned?—*Sir Russell Brain*: Yes; that decision was agreed at the time of the Spens Committee, and we feel sure it is right.

375. You still hold that view now as well as thinking it was right then?—Yes, indeed; I think it is essential for the maintenance of the highest possible level of all specialties. Also, medicine is developing so fast that we find actually some specialties gradually diminishing, which constitutes a problem in itself. A man may have trained in some sphere and ten years later you may find the whole picture changed; venereology is of course a striking example of that.

376. *Sir David Hughes Parry*: Can we come back to the main theme of numbers? If I understand your suggestion correctly it is this, that there are too many senior registrars now and too few consultants; and if there is to be an increase in the number of consultants and senior registrars the increase in number should take place in the consultant rather than in the senior registrar stage: is that right?—Yes.

377. And that practically all senior registrars, subject to this wastage, should hope within what period of time to reach the consultant stage?—It is difficult to limit that, because a very brilliant man may become a consultant after having held a senior registrar post for one or

two years, but we hope that normally after four or five years he would become a consultant, as in the past.

378. I am thinking still of the ten per cent. At what stage is the ten per cent. to be diverted, and where is the man who does not quite make the grade going to be diverted to; and I would suggest still that ten per cent. may not be right?—I think clearly if a man is going to be unsuitable the sooner that fact can be discovered the better, because it is difficult to tell a man after he has done four years in a particular field that he must do some other kind of work.

379. It is a difficult problem, is it not?—Yes.

380. *Mr. Bonham-Carter*: A man who is being appointed as a senior registrar is really being selected as a future consultant, and therefore ten per cent. is reasonable?—Yes.—*Dr. Cameron*: And that ten per cent. is in addition to part of your university wastage, in that the university lecturer is commonly selected along with the senior registrar; so it is really ten per cent. plus part of the university wastage.

Sir David Hughes Parry: What I am after is your contention, and I am putting the other matters to you to get your suggestion out fully.

Professor Jewkes: When your committee gives further evidence I wonder whether you would take special note of this table on page 64 of the Health Departments' FACTUAL Memorandum, which shows the change in the number of consultants, and so on, from 1951-1955. If you could let us have your comments on these numbers it would be helpful to us. I ask particularly because even if you settle the matter of equity between senior registrars and consultants there is another bulge which looks even worse, and that is the bulge of registrars, which have increased by 41 per cent. since 1951. So the whole question of demand and supply needs to be looked at and perhaps when you do present further evidence you could touch on that.

381. *Chairman*: I am going to ask *Sir Russell* whether it is on the whole his contention that anybody who gets beyond the position of house officer staying in the hospital service should eventually be able to become a consultant?—*Sir Russell Brain*: I am not sure I am quite clear about that. The man who is going

to become a consultant would normally pass through the registrar stage. But we should not maintain that anything like all who have been registrars would be suitable to become consultants.

382. What would you assume that they become?—Some would go into general practice, the services, the colonial medical services, public health, a great many other fields of medicine.

383. What sort of proportion of those who become registrars—not senior registrars, but registrars—would you think would eventually find their permanent home in the hospital service, and probably become consultants?—I have not got the figures I am afraid, but the proportion would be estimated by comparing the number of senior registrars with the number of registrars.

384. The answer is that at the moment there are about two registrars to one senior registrar—just roughly?—That would provide the answer. I think fifty per cent. of them would become senior registrars and of those ninety per cent. would become consultants.

385. *Sir David Hughes Parry*: In paragraph 18 you draw attention to the difficulty of recruiting registrars. I am not quite clear what is meant by that.—We are finding in many hospitals there are insufficient candidates for these registrar and senior registrar appointments owing, we think, to the fact that the men consider that the prospects of becoming consultants are poor. I have not any actual figures on this, but it is within our personal experience that the numbers of candidates are falling off.—*Dr. Hill*: There can be no doubt that the non-teaching hospitals, in particular the REGIONAL BOARD hospitals in the provinces, have had this complaint over and over again; there is an increasing difficulty in getting registrars and it is undoubtedly based upon the change of prospects, the optimism after 1948, and the pessimism now.

386. I wonder whether you would be able to provide some concrete evidence of that, having regard to your experience in certain appointments. It would help us.—*Dr. Cameron*: I can quote one instance in this last month, of a hospital in Edinburgh, where a registrar appointment for medicine was advertised. There was one applicant. He was from the

Commonwealth, and he was not considered suitable for the post. It is a non-teaching hospital, but it is a non-teaching hospital in a vast teaching centre, and even that is unattractive. Then, as regards the other hospitals I am afraid that the registrar position is such that the recruitment is from those who do not intend continuing in the Service—people who are going back to India, Pakistan and to other parts. That is one of the difficulties that we have to face up to.

387. We would like concrete evidence of this, and your submissions of the reasons for this, because obviously it is going to be an important matter.—*Sir Russell Brain*: We will do our best to provide that.

388. *Chairman*: Could you in any way distinguish between the teaching hospitals and the others or what you might call the centre and the periphery—or is that going to be rather complicated?—We will try.

389. Broadly speaking, I think you are not short of applicants at the better known teaching hospitals, are you? In fact, you probably have too many?—The special hospitals' experience is relevant there. In some hospitals they are having considerable difficulty in getting anybody other than overseas candidates for these posts.

390. For instance, mental hospitals.—*Mr. Sellors*: Even some of the more general branches of medicine. In my own branch we are almost entirely staffed by Dominions people.

391. *Sir David Hughes Parry*: I wonder if we could move on a little. Can we move on to paragraph 58? You are very critical of the recommendations in the report of the Committee of Enquiry into the Cost of the National Health Service, that a so-called new specialist grade should be introduced. I wonder whether you would like to elaborate that, because you only give one reason, in very general terms, that it is likely to result in abuse by underpayment for medical service.—*Sir Russell Brain*: I think, basically, what we feel is that, in the past there has been only one grade of consultant, and all men doing consultants' work have the same clinical responsibilities to patients; and that is a fundamental principle which should be maintained. That does not

conflict in any way with what we said earlier; that there are physicians and assistant physicians, surgeons and assistant surgeons—their training has been completed and their responsibilities are identical, though there may be some differentiation in their work in respect of out-patient sessions, operating days, numbers of beds, and so on. But we do not feel that it would be good for the service that there should be a second lower paid grade of consultant doing consultant's work.

392. Suggestions have been put to us by other bodies that there might well be a new specialist grade, intermediate between the senior registrar and the consultant stage, and you are quite firm on that, are you?—We are, indeed. We feel that it might lead to many men, and indeed it might happen to existing senior registrars, never attaining full consultant remuneration and status. They would be side-tracked and would spend their days in a lower paid level, although in fact doing the same work and with the same responsibilities.

393. In the last sentence of paragraph 15 you say: "Many men of adequate calibre are now not appointed until they are 40 years. . . ." I am not quite certain what is intended to be implied in the word "adequate". Do you mean just making the grade?—No. Fully trained and qualified consultants are not, as in the past, attaining consultant status at the age of 30 to 32, but are still lingering on in subordinate posts at the age of 40, even. I think it would be difficult to find anything parallel in other professional spheres.

394. *Sir Hugh Watson*: That is why the suggestion is made seriously by a very responsible body of your profession, that in order to counteract the sense of frustration which exists, owing partly to the presence of a bulge or bottleneck, there should be created posts of senior assistant surgeon, or senior assistant physician, which would carry with them a certain status, but would not go the whole way. You are dead against that?—We are. We feel it would really perpetuate the frustration of those most directly concerned.—*Mr. Sellors*: There is one point I would like to make on this. The actual terms of a consultant's appointment are those arranged locally. On one occasion a consultant may be appointed to a large unit of 30 or 40

beds, with a considerable degree of responsibility. Another consultant, who in the pre-Act days might have been called an assistant consultant, might only have half a dozen beds, and be more responsible for out-patient work, and so on. A great deal of this misconception of sub-consultant grades, which has been put forward, is not realising that a senior registrar, who is promoted to a consultant grade, need not necessarily go into a large unit of 30 or 40 beds. The number of beds he may hold, and the amount of responsibility, might be less than a more senior man in the service, but he still has the fundamental clinical responsibilities, and an equal place on the medical committee in voicing his own opinion, as would the more senior man. That is what we basically mean.—*Dr. Hill*: We do feel it important to demolish this case that Sir Hugh Watson quoted, because we are very familiar with it. It is rather like the 19th century labour problem that used to occur, I believe, when labour was exploited. If you had an excessive number of people for a limited number of jobs, then you could employ them at a sweated rate, and this is nothing more than that. There are not enough consultants, and too many registrars, some of them now approaching middle-life. Why not hold them out a poor sort of lifebuoy, as an opportunity to exploit them? It is nothing less than that. In discussing this, for example, with colleagues on my own REGIONAL BOARD, our view is that if this grade were introduced, virtually 100 per cent. of their work would be full consultants' work. It would be sheer exploitation of men, which would not ultimately be in the interests of the service, to create a new special grade for them. The secret of overcoming this advancing age of 40, which applies to the acute clinical branches of medicine and surgery, is to alter what some people call the ratio, to increase the number of consultants and diminish the number of senior registrars and registrars. It could be done with good planning on the REGIONAL BOARDS, with probably very little net increase in financial cost to the State.—*Dr. Cameron*: There are two other points that I would like to bring forward, but before I do so let me make it clear that I am of this body from which Sir Hugh is quoting, but I am not of that body's opinion. I want to make it clear that, though I

am from that COLLEGE, my own opinion is contrary to that expressed in the memorandum.

395. *Chairman*: But still it is a respectable body?—Wholly. I would not be Vice-President of it, otherwise.

396. *Sir David Hughes Parry*: May I say that they are not the only body that put it forward?—No, I understand that. There are two further points. The first is that from the public viewpoint the likelihood is that those junior men would be in areas outwith the main teaching centre areas, and there would be two standards of medicine in different parts of the country. We cannot have the senior medicine in the cities and the junior medicine in the rural areas. The other even more important point, I think, from your aspect, is recruitment. It has to be understood that the senior registrars and the registrars are, themselves, as you will see from their evidence, opposed to such a grading. That opposition spreads lower down than the senior registrars, even to house posts. You are going to detract from the attraction of the consultant grade, if you introduce a second grade, and you are actually going to oppose recruitment to the hospital service, instead of facilitating recruitment to the hospital service.—*Sir Russell Brain*: I think that is a very important point. One of two things might happen; either this junior grade would move up by seniority, or it would move up by selection. In the first place, you would have considerable friction with consultants not being paid the full consultants' remuneration, which must diminish the attraction of the consultants' branch of the Service. Alternatively, and this I think is the more likely, you would have men marooned permanently in a lower grade and never able to become full consultants; and that would have an even worse effect, because no man entering the service would have any guarantee that he would achieve the full remuneration.

397. We have got your views perfectly clear in our minds.—*Dr. Hill*: I hope we have expressed it strongly enough.—*Mr. Bonham-Carter*: It is a logical sequence of the earlier answers, is it not, about the purpose of the senior consultant?—This is some deviation from

the road to the celestial city, which at first is a little tempting, but it is full of sinners.

398. *Chairman*: It has seemed to me that there is a difference between the staffing and other positions in teaching hospitals and in the periphery and in some specialties, and perhaps you could bring out in your further information any facts which you think would be useful?—*Sir Russell Brain*: Yes, indeed.

399. *Sir David Hughes Parry*: I think we might move on to paragraph 40. "It is important to recognise that a part-time consultant cannot divest himself of responsibility in his hospital during periods of the week when he is not normally working in the hospital." It is just a small point; but I am not quite certain what you mean.—That means this, that at any time he may be telephoned about his patient, at any time he may have to go down to the hospital, at times when he is not normally attending sessions there, for emergency purposes. In other words, once he has a patient in hospital under his care, he is continuously responsible for that patient, whether he is attending hospital at the time or not, or whether he is rung up or not. He always has his duty, although he is labelled a part-time consultant.

400. And a full-time person, although he only does a certain number of hours, is in exactly the same position?—Yes.

(The proceedings were adjourned for a short time.)

On Resumption

Chairman: We were on paragraph 41. Sir David was telling you that we were going to ask you a few questions on that.

405. *Sir David Hughes Parry*: I wonder how far we can take that today. Perhaps you would like to wait until we have the second memorandum. I am referring to paragraph 41, in connection, first of all, with the full-time and part-time consultant work.—*Sir Russell Brain*: Yes, I see. This is a matter which we have dealt with very fully in our second memorandum, but we shall be very glad to deal with it today if the Commission so wish. We can really summarise what we have said in our second memorandum, and perhaps

401. He has the responsibility in the middle of the night?—Yes.

402. So that the responsibility is the same in that way?—In that respect, yes.

403. *Chairman*: I think we shall want to come back later to this in more detail, as to whether that has achieved the particular result that was envisaged, or not.

Sir David Hughes Parry: I would like to open on the question of a salaried service, but having regard to the time, Sir . . .

Chairman: I think we might, perhaps, break off now.—Could Sir David refer to the particular paragraph on which he is going to raise that?

404. *Sir David Hughes Parry*: It is paragraph 41, and there are two matters in particular that I would like to raise; the question of part-time consultants and full-time consultants, and also the question of a salaried service. Those matters have been put to us already in evidence, and we would like to hear you elaborate some of the points that you made here.—Yes. We have dealt with the part-time and full-time very fully in our second memorandum, and perhaps we could consider that during lunch-time.

Chairman: We will start again at 2.15 p.m., if that is convenient to you.

reserve the right to return to it later if we want to.

406. Would you summarise now, very generally?—The question being the advantage or disadvantage of a whole-time salaried service?

407. That is right.—I think what we would say is this. First of all, the existing arrangement for part-time consultants fulfils a social need and requirement, the reason being that it enables doctors to give to certain patients more time than is available in their ordinary hospital work. That does not mean time devoted purely to the routine of medical examination, although that comes in, but also to the discussion of many personal problems related to their future and so on, which in certain cases need to be discussed at considerable length. If the

need for that is admitted, it seems to us impossible that the State could ever afford to provide that service on that scale, and therefore if it is to be provided at all it must be provided as it is now, privately. Coupled with that is the freedom of the choice of the doctor by the patient, which is really at the bottom of one aspect of the patient/doctor relationship. Under the Health Service the patient has no freedom of choice, either as to whom he should consult as an out-patient, or under whose care he should be placed in hospital; and inevitably many patients who come to the out-patients are seen by registrars, under the supervision of consultants, and they may be transferred to the list of another doctor, if his waiting list is shorter for a hospital admission. That seems inevitable in the working of the Health Service, so that if a Member of Parliament, let us say, under a whole-time salaried service, wished to have medical treatment he would have no choice as to the doctor he would see, nor would any particular doctor be under any obligation to see him. That, I think, is a point of some importance. If we look at what I might call the mathematics of it—I will not go into this in any detail, unless you wish—if we suppose that all part-time consultants now were made whole-time, the net result in consultant man hours would be comparatively small, because most of them are averaging 7 or 8 sessions a week. If they then did 11 in that time they would still have to see all the patients they were seeing in private, who would come under the salaried service, and the margin would be comparatively slight. That, I think, is a small point. At present very few consultants are outside the Health Service. If you had a whole-time salaried service it is quite probable that many of the best men would prefer to practise outside it, and that we feel would be very regrettable. Finally, and perhaps most important of all, we think that the existence of a part-time service is extremely important for the maintenance of the independence of medicine in this country. We believe that it would be most undesirable that virtually the whole medical service should be in a salaried form, the doctors being in effect medical civil servants under a directorate of one of the Ministries, and we think it is quite vital that there should be, if you like, competition—at any rate, free-

dom and independence—for such doctors as wish it in part of their work. Those, I think, broadly are the arguments.

408. May I take up the last thing that you said, about freedom and independence in part of their work? The work is divided now into elevenths, is it not? How many elevenths do you think would be sufficient to give them this independence?—I doubt if it could be numerically computed. Freedom is something that is difficult to measure.

409. If they had only one-eleventh or two-elevenths there would not be much, would there?—No, I think that is true. There are different aspects of it, are there not? There is the spirit of feeling free, that you can do things for part of your time in your own way, and be answerable to nobody but yourself, in any sense of the word. There is also the financial aspect of freedom, which cannot be so large, and it can be measured only in terms of three or four-elevenths, but it is still something substantial. It gives a man freedom in his own time to add to his remuneration, in relation to his power to convince his colleagues and others of his efficiency, which is a very important psychological factor.

410. The man who does nine-elevenths is practically full-time, is he not?—Yes. He is practically full-time but he has this precious margin of freedom to see private patients out in consultations, and so on, which he would not have if he was a whole-time salaried servant.

411. And you lay emphasis on the element of independence and financial independence?—Very much so, yes.

412. On the other hand, you would agree that a certain number must be full-time, so as to be there for administration and for immediate call? You are contemplating, are you not, a combined operation of full-time and part-time?—Indeed, yes. I think that is very important, and we should not in any way want to depreciate the value of a full-time service. Some people do their best work in those circumstances, and there are certain types of work which can be better done in those circumstances. We would like to see a friendly rivalry between the two, showing that each has its own contribution to make, and, therefore, each can indirectly benefit the other.

413. You could not help by indicating the numbers, percentages or proportions? We shall have to keep that in mind.—That is a thing which we have not addressed ourselves to, and I think if we were asked to do it, we would rather leave that for the moment. I am not quite sure whether there is an answer. It might be a very wide margin workable either way, but we have not specifically considered it.

414. *Chairman*: You will know, of course, that there is a very great difference between the proportion of whole-time consultants in some specialties, and that in others?—Yes. That, I think, is rather inevitable. If you take the mental health world, for example . . .

415. *Sir David Hughes Parry*: Why should there be these variations?—I think it depends so much on circumstances of practice. Where a doctor has to be largely residential in order to keep a continuing watch-over hospital patients, and where at the same time there is not much demand for private consultations in that sphere, then you will tend to have a large proportion of whole-timers. I think it depends on a number of varying circumstances relating to the actual work. But I think in recent years quite a number of men who have been whole-time have given it up and become part-time.

416. Can you indicate any reason for that?—I think the reasons are set out in our second memorandum, that for certain reasons, even financial, it is advantageous to be part-time, apart from the other arguments we have mentioned.

417. In what way are the financial advantages rather weighing in favour of the part-time? That is what you are really saying, are you not?—Yes, indeed. There, again, it is set out in great detail in our second memorandum, and I do not know whether it would be better to leave it, rather than for me, perhaps, inadequately to present the reasons.

418. *Chairman*: Could you say whether you think that there ought to be any special attraction to become part-time, or not?—We have always accepted the principle, which has been accepted by the Ministry, that unless there are important overriding considerations any man should be given the choice of whether he would work whole-time or part-time in any particular appointment.

419. Do you think freedom should have a price, or should freedom be able to be obtained for nothing, or even at a financial advantage?—We think that the financial disadvantages of being whole-time should be removed, and certain clauses of the Spens recommendation, for example, which have not been implemented, should be implemented, and where the income tax differentiates to the disadvantage of one, that differentiation should be removed. There are other points, such as the fact that the whole-timer now has to have 8 domiciliary consultations per quarter before they begin to count for remuneration, and so on. We see no grounds for this differentiation.

420. I take it that you four gentlemen, in fact, are all part-timers. I do not know if that is so, but you might have been; you might equally have been full-timers?—*Dr. Cameron*: We probably would not have been in the service if we had to be full-timers.—*Sir Russell Brain*: We are, in fact, part-timers, but we have, of course, the advantages of hearing the views of the whole-timers, and we have seen the memorandum of evidence and have discussed it.

421. We have had the whole-timers to talk, too.—*Dr. Hill*: Perhaps I might use myself as a guinea pig. I am a maximum part-timer, but in practice I do more than whole-time sessions. I have chosen to be a part-timer not for any financial reason, but because of that blessed element of freedom, and there is an escape clause which is much bigger, in fact, than Sir David really suggested. It is a much bigger breathing space than you might expect. It means that almost any day of the week I can act like a free professional man, and it is that little escape clause, from feeling myself a whole-time servant—an officer of Whitehall or Savile Row—that makes all the difference in my life. I can still feel myself a professional man. I would say that I am speaking for the great majority of maximum part-timers, and 70 per cent. of part-time consultants are maximum part-timers. I should think that it was in the public interest that there should be that small escape element for a high percentage of medical men in this country.

422. *Sir David Hughes Parry*: But there is a weighting, is there not, in the remuneration of the part-timer? He gets

a little added remuneration. One way of equating them might be to remove that?—It might be, but there is some symbolic value in that. Even when I am outside my sessional hours I am still responsible for the patients in the State hospitals. It does not mean very much. It is a financial bagatelle, but it has some symbolical value, and the Ministry of Health recognise that, because, as Sir Russell Brain said, we have long had an understanding with the Ministry of Health that, unless some very material reasons can be adduced otherwise, the consultant when appointed should always be given a choice of either being maximum part-time or full-time. The authorities know perfectly well that a maximum part-time man will put in just as much work in the State hospitals as if he were eleven-elevenths, and the practice of many Boards is to follow this quite strictly. My own does. If they advertise a post full-time or maximum part-time, they will appoint the candidate; and after they have appointed him they will call him back and ask him if his choice is to be maximum part-time or full-time.

423. *Sir Hugh Watson*: And being acquainted with the income tax laws, you would probably choose part-time, would you not?—I am not acquainted with the income tax laws, although I have been under them since 1948. That did not influence me in the slightest.

424. We were impressed by what the whole-time consultants told us the other day. They went so far as to say that the difference in income between the two types of consultant is having important disadvantageous effects on the hospital service.—That is an extreme statement, in my opinion, and I have been mixed up in these discussions from the start. One must remember that if you are part-time you may have some income tax advantages—on your car, for example, and on your consulting room—but, on the other hand, your overheads will be heavy. The practices of many maximum part-time consultants, just from the cold business point of view, are not really worth while; but it is their freedom which they enjoy—the fact that they are not body and soul an officer of the Minister of Health.

425. *Chairman*: Do I take that to mean that, on the whole, a man on nine-elevenths part-time will probably be earning either less or certainly not more

than he would have been on eleven-elevenths whole-time?—Yes. I do not mind making a personal revelation. My own accountants tell me that my actual profit from private practice, after my overheads are deducted, is in fact negligible, but I would not change to whole-time for anything.

426. And you would think that that might be representative of the profession?—I would say it is representative of a very large number of maximum part-timers today.

427. *Sir David Hughes Parry*: What you say, really, is that the profit is negligible after deduction of certain allowances which the full-time man does not get?—That is right. After all that is allowed for, I am informed by people who know better than I do—

428. The complaint of the full-time man is that he does not get the allowances that are deducted in order to arrive at your profit figure?—On the other hand, he does not have my overheads. I think I am fairly typical.

429. *Chairman*: I take it that it has never been suggested that a part-timer should be able to be ten-elevenths. You are quite content that the maximum part-timer should not be more than nine?—We were certainly quite happy about that in 1948.

430. I am talking about now.—It has never been suggested since.—*Dr. Cameron*: I think it has to be recalled that nine-elevenths does not mean nine-elevenths of your day; it means nine-elevenths of the working hours allotted as the computation for a whole-timer, and that leaves a large amount of the man's day, in which he maintains his independence. He can go and grow cabbages; he can do anything in that time. It also has to be recalled that the fact that a man is a whole-timer does not prevent him from accepting other appointments. He may be a whole-timer, and he may be a director of some firm. That is quite well known in both university and other circles, and being whole-time does not mean that you are entirely tied down to nothing but the work of the hospital service. I think that probably one of the best answers that could be given to you on this question was the evidence that was laid by the Governor of the Bank of England at Monday's enquiry, where he was

asked why the directors of the Bank of England were not whole-time. I think you get the perfect answer to your question there, Sir.

431. *Professor Jewkes*: If we assume, which seems to me inescapable, that there have got to be part-timers and whole-timers is there an optimum distribution between the two?—*Sir Russell Brain*: That we have not really considered, and I think we would like to think it over before we answer that. The question has not been put to us before, I think. There are, as I think we have hinted already, certain specialties where the need for whole-timers is obviously very great. In general, radiologists now, I think, tend to work at their hospitals, where they need expensive apparatus. Pathologists, broadly, are not people who do much private practice; their work is mainly hospital work. Many psychiatrists would naturally be whole-time. I think it would have to be broken down; and we would like notice of that and try to deal with it next time.

432. If you could just keep this in mind, this is a point that was made to us by the whole-time consultants at our last public hearing. The whole-time consultants were suggesting that there had been an important drift from whole-time work to part-time work, and that this was really bad for the service as a whole. There are two matters involved: how much of a drift has there been—and perhaps we could find that out ourselves—and the other question is whether, if any drift has occurred, that is really a disadvantage to the service. Only you can tell us that, so perhaps you would enlarge on that?—*Mr. Sellors*: I think the drift that may have occurred in recent years is since the Ministry agreed with ourselves that a man should have the choice between whole-time and maximum part-time; in other words, it was the individual choice of the practitioners in that. One other aspect is the reaction of the public as a whole, and the implications of a whole-time salaried service, which would mean that unless you had practitioners completely outside the Health Service, which inevitably might take some of the best people, you would not have that same freedom of choice that you have at the present time.

433. *Chairman*: Might I ask what proportion of the population exercise

such a choice? Have you any idea?—*I do not think one could say.*—*Dr. Cameron*: A measure of that might be obtained from the growth of provident schemes.—*Dr. Hill*: I am sure that the development of the part-time consultant is wholly in the interests of the Service. I should have thought that it was most desirable, as with the lawyer, that the senior type of doctor, the consultant, should feel himself a man of independent status and stature, and not an officer of an authority for the whole of his life.

434. When you say a senior type of consultant, you are not differentiating, particularly, because you only have in mind the one type of consultant, at any rate in the eyes of the public and the patients? Is that right?—*Yes*. I was referring to the whole consultant grade.

435. Would you think, Sir Russell, that if there were any marked tendency for people in the hospital service to go over to or away from one particular distribution—for instance, either to middle part-time or whole-time, or maximum part-time—that that might indicate that the relative financial advantages were perhaps not working out as had been anticipated?—*Sir Russell Brain*: I think that would undoubtedly be one factor, but I think there may well be more than one, as there so often is.

436. Let me put it the other way. If the distributions are thought to be round about right, always allowing for a certain amount of fluctuation, would you think that the financial inducements ought to be such as to encourage maintaining that?—*Yes*, I think that is true, but I find it very hard to know how one would decide what was the right distribution. It seems to me, as I said, a thing that might work well over a considerable range. I am not sure what criteria one would apply.

437. *Sir David Hughes Parry*: But you would agree that a minimum of full-time persons is required to run a particular hospital?—*I am not sure what that means*. I think I have agreed that in certain spheres of medicine there should be a considerable proportion of whole-timers; but whether it is true that some are required in every hospital, I would have to think about that.

438. It has been put to us very strongly that with the part-time consultant there is a good deal of waste of

movement, and so on. A part-time consultant may be operating at two, three or four different places, and he would be moving from one to the other, and it is not easy to organise the work. Have you experienced any difficulty like that at all?—*No.*—*Mr. Sellors:* That is not necessarily a disadvantage. It may be an advantage to have a man working at more than one or two hospitals.—*Dr. Hill:* That may have been put to Sir David too strongly. A maximum part-time man, or even rather less than that if he is a conscientious man, as most of us are, can put in just as much work at a hospital as a whole-time man. I would even go so far as to say that very often a part-time man would put in more. He will set no limit. He will not count his hours. If he is needed in his hospitals he will be there, and will not bother whether he is being paid for this particular hour, or not.

439. *Chairman:* Does that not apply to the whole-time man, also?—To a man of a conscientious nature, it does not matter which he is. He will give his time in the same way. It is quite wrong to assert that a man, because he is part-time, will be absent when he is wanted. Some whole-time men have their services divided between a number of hospitals, and they may be in one, and are wanted in another. As a matter of fact, we have agreed with the Minister of Health, on a long-term policy, that that should be limited. It is a very good thing that a man may well be connected with more than one hospital, but we agree with the authorities that a man should not be connected with so many that he spends a lot of his time on the road acting as his own chauffeur. But it is a great mistake to believe that to get the best service out of a man in a hospital he must be whole-time. It depends entirely on the man and his sense of duty and his conscientiousness.

440. *Sir David Hughes Parry:* We have had evidence already given to the contrary, that is to the effect that there is some difficulty in making these arrangements.—I would say there need be none at all. It depends entirely on the man and the administrative skill with which the job is done. As a matter of fact, today most new REGIONAL BOARD consultant appointments in medicine and surgery will be found to be fixed between one or two hospitals, at the

most. Most of these difficulties were hangovers from before 1948.

441. *Professor Jewkes:* May I just ask this? Before 1948, who did the kind of work in the hospitals that is now done by the whole-time consultant? Before 1948 there was no such thing as a whole-time consultant.—*Mr. Sellors:* Yes, there was.

442. But they have become much more numerous, have they not, since 1948? Is that it?—*Sir Russell Brain:* I am not sure. After all, in all municipal hospitals there were many whole-time doctors doing consultant work, as well as visiting part-time consultants. That is also true of the mental hospitals, which were entirely staffed by men working whole-time. In teaching hospitals, of course, there was the academic staff of universities, who were whole-time, Professors of Pathology and so on, so there was a good deal of whole-time work done, and I think we would need figures to say whether that has gone up or down. I do not know.—*Dr. Hill:* But the real expression of opinion dates from the days before the SERVICE, when we really had two hospital services in this country—the local authority hospital service, where the vast majority of men who did the day-to-day work were whole-time officers of the local authority. They were not always what we would have called of consultant status. In fact, to accommodate many of those people, without making the consultant status look ridiculous, the S.H.M.O. grade had to be created in 1948. In the other grade were the people like us, who worked for nothing as consultants in our voluntary hospitals before the war. We were paid nothing at all, and earned our living in consulting practice. Many of us, and certainly Sir Russell and myself, were part-time consultants to local authorities before the war.

443. *Sir Hugh Watson:* The consultants in the voluntary hospitals, who were whole-time, were not whole-time consultants in the sense that Professor Jewkes is talking about today. They were not paid anything by the hospital?—*Dr. Cameron:* Some were. For example, radiologists in the hospitals were whole-time technologists.

444. But the great majority were paid nothing?—*No.*

445. *Professor Jewkes*: In the voluntary hospitals there would be only a relatively small number of what we call whole-time consultants?—*Dr. Hill*: Yes.

446. *Sir Hugh Watson*: You deal with this in paragraph 29.—I am afraid part-time and whole-time does not really come into it. A consultant on the staff of a voluntary hospital, would give for nothing all the time that was needed for the welfare of his patients.

447. *Professor Jewkes*: What I am trying to get at is this. I do not know whether this would prove to be the case, but suppose it were discovered that in the last two or three years there had been a 10 per cent. drift from whole-time to part-time. Is that the kind of thing that ought to alarm the profession? Is that the kind of thing that we should take note of in trying to restore some sort of balance in payments between the two groups, or is it something that could go on without the efficiency of the service really being affected?—*Sir Russell Brain*: I know of no evidence that it has affected, or would be likely to affect, the efficiency of the service.

448. *Mrs. Baxter*: Would not this drift from whole-time to part-time be at least accounted for by the development of the provident associations, whose servicing provides considerably more work for the part-time man to do in his own time?—I think that is a factor. It is very difficult to estimate it, because it is complicated by another point that we raise in our second memorandum, and that is the very high charges for private beds, which operate in the other direction, and which make it very difficult for provident schemes to provide adequate cover.

449. That, of course, varies very much with the area, does it not?—It does vary, but the general tendency, like everything else, is steadily upwards. But I think, undoubtedly, the growth of the provident schemes, which surprised everybody after the health service came in, is a factor but not, I would have thought, as yet a very large one.

450. And this would be a factor which would affect the younger men a great deal more than the older men—the younger part-time consultants?—Yes, it would.

451. So that one would expect to see a division of opinion, as to the desirability of full part-time, as opposed to part part-time?—Yes, I think that is so.

452. *Chairman*: I have understood both Dr. Cameron and Dr. Rowland Hill to say that if you are only doing nine-elevenths nominally you are, in fact, able to do as much as if you were on eleven-elevenths, with a considerable amount of part-time practice, as well?—*Dr. Hill*: Yes.

453. Does that mean to say that the full-timer's commitment is based on a rather smaller amount of total time spent, than would be spent when the doctor is more completely his own master?—Broadly speaking, yes.—*Sir Russell Brain*: If one takes the time devoted to the practice of medicine, I think it is probably true to say that the man who is doing nine-elevenths part-time, and a moderate private practice, is putting in more time than the average man who is doing his whole-time service.

454. *Sir David Hughes Parry*: But you would agree that the man who is doing a full-time consultant's job is also taking away with him a good deal of responsibility to his own private house?—I am not sure I follow that, but I do not think there is any difference between the part-timer and the whole-timer, in that respect. They are both taking continuous responsibility for their patients.

455. Is the responsibility of the full-time person even greater?—*Dr. Cameron*: I would rather put it the other way that the whole-timer usually has associated with him whole-timers to take responsibility, whereas the part-timer most commonly has associated with him another part-time consultant. Therefore, the continuing responsibility is greater on the part-timer than on the whole-timer.

456. I am sorry, I do not see that.—My point is that he is in effect covering the whole 24 hours, and there is no opportunity to relax, whereas the whole-timer knows that he has responsibility for a period of duty from, say 9 to 5, and if he has administered his charge correctly the responsibility is now on the shoulders of his colleague. Many of the whole-timers have a system of periods of duty, if I can put it in that way.

457. Suppose that during the night there is an acute case. Will they summon a part-time person there?—Yes.

458. Will it not be the full-time person who will be called upon, in the first instance?—No.—*Sir Russell Brain*: There is no inter-mixture where a part-timer is responsible for beds. He is wholly responsible, and he is appealed to in the middle of the night. His whole-time colleague is responsible for another set of beds.

459. *Mr. Gunlake*: Is there anyone at the hospital who would relieve the part-timer in such a case?—He has his subordinates and his registrar, who might or might not be resident at the time.

460. So a part-timer would be called upon if someone lower down the line felt that he must be called upon, but not always? The crisis could, perhaps, be dealt with by not calling on him?—That applies equally to the whole-timer and the part-timer.

461. *Sir David Hughes Parry*: But there would be a disposition to call upon the full-timer more readily than the part-timer?—*Dr. Cameron*: That is one thought we must destroy, Sir. The part-timer is equally responsible. It is a personal responsibility, be he whole-time or part-time, and the condition of the service is such that it is equal in both part-time and full-time. I would resent it if anyone else were being called to accept responsibility for my patient.—*Dr. Hill*: I think it might help if we said that, despite nearly ten years having gone by since 1948, the old local authority hospitals and their staff, and the old voluntary hospitals and their staff, have not yet been completely assimilated; and you will still find the whole-time clinical staffing persisting in what before 1948 was a local authority hospital, and the part-time staffing persisting in the old voluntary hospital. What you do not find very often in a hospital are two part-time surgeons and one whole-time one. The whole-time surgeons and physicians are to be found in a hospital, which ten years ago belonged to the L.C.C. There probably is not a single part-time surgeon in many such hospitals. They are probably all whole-time officers. Whereas, in a voluntary hospital they are probably all part-time surgeons. The marriage is not yet complete.

462. That may very well explain it.—*Sir Russell Brain*: There does seem to be a misunderstanding about the responsibility of the whole-time and the part-time staff, and it seems to be thought that the whole-timer has greater, more continuing responsibility than the part-timer, but that is not so. The clinical responsibilities are identical.

463. *Chairman*: I think it was rather implied in your memorandum, Sir Russell, that perhaps the responsibility of the part-time consultant was greater, though I do not think you meant to imply that. It is paragraph 40.—There is not here, nor was there intended to be, any comparison with whole-timers. It is merely a statement of fact.

464. I think we are clear on that now.—*Dr. Hill*: For example, there are two hospitals of mine that I visit normally once a week, to do out-patients and see patients in the ward, but I consider myself responsible throughout the whole week for the patients under my care in the wards, and I expect to be communicated with by my subordinates if they are worried at any time, day or night, and that is true of all part-timers.

465. *Sir David Hughes Parry*: If I understand the position rightly, you say that there are three main advantages for the part-time consultant. First in importance you put independence; secondly, there is a certain amount of weighting in favour of part-time consultants in the matter of remuneration; also, that there are certain income tax advantages, which are not very great. Those are the three main things?—*Sir Russell Brain*: May we distinguish between the advantages in society of having a part-time service? There are advantages in the consultants, financial or otherwise, which you have mentioned, but I think there are advantages to society, as we see it, that we did mention.

466. The advantages so far as remuneration goes, and the advantages of the general professional standing?—Yes, I think we should distinguish those.

467. *Professor Jewkes*: Just to confirm this, because I do not think it appears in this evidence, your committee is in favour of a change in the arrangements about payments for domiciliary visits in the case of whole-timers, is it?—Yes. That appears in our second memorandum. We are in favour of

their being treated in exactly the same way as part-timers.

468. *Sir David Hughes Parry*: May I move on? The next matter to which I want to draw attention is what you say about merit awards. We have been looking at this matter from two angles; first of all, the system as such—whether it is a good system, or whether it might be replaced by a system of weighting in respect of certain appointments—and, secondly, the method in which the awards have been made in the past, and are now, in fact, being made. You are in favour of the system. Would you like to enlarge on that?—I would, personally, say that the invention of merit awards was a great imaginative stroke in the setting-up of the health service. I think it was a great achievement. It meant that increased remuneration could be given. It meant that a few could receive scales of income which enabled medicine to compare in attractiveness with the other professions and walks of life. It did that without accepting the principle of seniority, which may be a necessary and suitable method in some services, but which we feel has undesirable features, in that there should be some way of discriminating between merit and mere seniority. Those, I think, are the reasons why we thought at the time that it was an excellent idea, and we think so still.

469. You make it quite clear that these are the advantages elaborated as you see them.—Yes.

470. We have had several indications that the system as such is not acceptable throughout the profession. Have you any evidence of that, or of the general acceptance of it?—Naturally, nothing is without criticism, and there have been criticisms voiced in the medical press of the method, but I think that the evidence in its favour is shown in the evidence, which you are going to receive from bodies representing the whole profession, that they are strongly in favour of the system and have no substantial criticism to offer of the way in which the awards are made. That is our view, and I understand that is to be the view of the British Medical Association. I would say that, in spite of individual comments, we have no evidence of any substantial criticism in the profession of the method by which the merit awards

are made. I, myself, was a member of the Merit Awards Committee, and I can speak from personal experience.

471. Have there been any changes in the personnel of the awarding committee at all? Have the personnel varied during the course of the nine years, or are they the same persons?—No, indeed. It is appointed by the Minister after seeking advice from various bodies, and there have been frequent changes. I have not got the figures.

472. In the committee personnel?—Yes.

473. All this is very mysterious, because all this is done in secret, is it not?—*Mr. Sellors*: The Committee of which I am Chairman is a democratically elected body, and they usually think that this is a matter for discussion. But this year when we discussed it for several hours, and a final vote was taken, it was in unanimous support of the merit award system as it stood.

474. And as it had been administered?—And as it had been administered.

475. *Chairman*: There are two points, the system and its administration. Do I take it that your answer really comes to this...?—We are satisfied with both, and it is really, I think, very unexpected to have such unanimity in such a very widespread body with so many interests, whole-time and part-time.

476. *Sir David Hughes Parry*: It was unexpected, because there has been criticism?—Because there has been criticism and, inevitably, there will be criticism, partly based on some aspect of secrecy.

477. *Mr. Gunlake*: One aspect in particular has been put to us, and that is that when a merit award is made no one is informed who receives it, so that it might be possible for some medical men in a hospital to have merit awards, and the others would not know about it. Have you any feelings on that particular aspect of secrecy?—*Sir Russell Brain*: I think the reason given in the past for that was simply that it was undesirable that merit awards should be public, in the sense of being known, as they would be, to the general public.

478. May I make this quite clear? The criticism was that they were not

made known to other doctors. It was never suggested. . . .

Mr. Bonham-Carter: The point made, if I remember it rightly, was that a merit award might be given to a junior, and his own senior would not know.—*Dr. Cameron:* I suggest that that is desirable. In order to maintain the amity and harmony of the hospital staff, it is desirable that such things should not be known.

479. *Chairman:* It has been put to us that it might lead to suspicions, as to who was getting it. It is a question of secrecy, but nobody has suggested in our hearing that the public as a whole should hear it. That is quite a separate point, but it has been suggested that other doctors, not merely the seniors of the doctors, themselves, should know.

Mr. Bonham-Carter: I think it was said by the witness "My junior might get it, and I would not know".—*Sir Russell Brain:* I, personally, would feel that there is no objection to that, and that it is not undesirable that there should be secrecy throughout. You will probably be obtaining evidence more directly in relation to merit awards and the system adopted. There are very complete consultations, and I know it is the practice in many hospitals for the Medical Committee to appoint a small sub-committee of senior members who, themselves, every year put up recommendations, and who, themselves, have before them a complete list of holders and potential holders of awards, so that there is not, by any means, complete secrecy even there. But I would think that these are really matters that others, more experienced in the working of the procedure, could advise you better upon.

480. *Chairman:* It must have a very direct bearing on anything we may recommend, eventually, on remuneration, Sir Russell, because if there is a large number of people getting something over the basic, then the basic will presumably be rather different from what it would be if the basic was really the sum total received by them?—Indeed, and, as you will have heard, when the system of merit awards was set up it was an alternative to a wider spread of that amount of remuneration. It was not that extra money was provided, but that the money was so divided.—*Mr. Sellors:* The senior members who make their

annual recommendations are aware of the position, but, naturally, they do not diffuse the information through the hospital.

481. Could you say whether the inability to advertise the possibility, or at any rate the promise of a merit award, would ever make it difficult to secure somebody from overseas for some teaching post, or anything like that?—*Sir Russell Brain:* I have never heard anything like that. I have never heard merit awards entering into specific inducements to a post.

482. I have one other question on that. Merit awards have remained, as far as I know, at the same figure ever since they have been established. It has never been suggested that they were going to be subjected to anything which might be called betterment, has it?—It will be, Sir, in our second memorandum.

483. Because in Spens it did not seem to me that the question of leaving the value of money to others to decide, excluded merit awards.—No. We feel that if merit awards are not increased their attractiveness steadily diminishes until their relative value becomes extremely slight, and their original purpose would no longer be served.

484. That, again, would have considerable bearing on any other level of the general level of salaries.—Assuming that the total sum is circumscribed or limited.

485. *Mr. Watson:* Would you think that the service would suffer if merit awards were abolished altogether?—Indeed, I do. I think medicine has been getting a remuneration which compares favourably with that of other people of equal success in other professions, and if these were abolished altogether, I think it would cease to do that, and if it was based on seniority, I think it would cease to attract many people.

486. *Chairman:* Would you count seniority as being roughly the same as responsibility? It has been suggested to us that a specially high remuneration should apply to what we call positions of responsibility. Do I take it that that is broadly the same as seniority?—I think it would be very difficult to define. I would want to know how one would evaluate responsibility, but I think in

practice that when people have more beds, as they become more senior, and so on, it would mean seniority.

487. We have asked the Ministry to give us some more facts and figures. We know what proportion of the total consultants enjoy a merit award, but we have asked if they can give us some estimate of how many, in the course of their careers, will at one time or another receive an award. That would, presumably, be a much higher percentage?—Yes, indeed it would.

488. I do not know whether you would like to say if you think, for instance, that if one-third had it at any one time probably over two-thirds, in the course of their career, would have it?—I think it is something like that. From the point of view of the attractiveness of the profession, it is not what number get it now, but what are the chances of an individual entrant getting it, eventually.

489. *Sir David Hughes Parry*: Are you going to suggest that the number should be increased, so that the proportion of the merit awards may be maintained? At the present time there is a certain limit, is there not?—No, we are not suggesting any change, I think, in any sphere in the organisation and grading of the health service.

490. *Sir Hugh Watson*: Sir Russell, you mentioned rightly that probably we should be getting evidence from the people who administer the merit awards, as to how they do it, and we will be concerned with that, of course. But we are also very much concerned to know whether the existence of the system, and its administration, commends itself to the whole profession, as far as you know?—Except for minor exceptions I think it does. We have no evidence that there is any widespread disapproval.

491. We have heard it said that the merit awards are, themselves, administered by people who hold merit awards. I am not meaning that in any unfair sense: but the whole question of merit awards is being considered by senior people, and young men do not come in. Can you tell us about this?—Inevitably, I think, merit awards must be considered by senior people, whether it is a recommendation from the hospital, or at the highest possible level, but there is the fullest consideration given to every individual. Every potential candidate is

considered, and when a man becomes a consultant he is asked to furnish to the Merit Awards Committee particulars of his career, of his publications, in other words of anything on which a merit award could be based, and to keep them up to date. And he has the opportunity at any time of applying and asking why he has not been given one.

492. *Chairman*: I think, Sir Russell, it would be very useful if you would take further steps to be able to show us that it is the view of the profession as a whole that the system is a good one.—We speak, as you have heard, Sir, for all the Colleges and Corporations, and the Central Consultants and Specialists Committee, and it is the view of all those bodies that the system is satisfactory, and it is satisfactorily worked.—*Mr. Sellors*: I think a great deal of publicity and criticism has come from wider bodies of the profession than the representative body of the Association. The criticisms have largely come from other branches of the profession than the hospital service. I think that some general practitioners and public health people have criticised the method and the whole system.

493. *Sir David Hughes Parry*: They have given us the impression that the criticism comes from the lower stages, rather than the higher stages, of the profession.—*Dr. Hill*: I think an accurate summary of this position would be this, that the overwhelming view of hospital consultants is strongly in favour of the principle of merit awards, but like any collection of human beings—and I do not think it is in any way an exaggeration—there will be a small percentage of people with chips on their shoulders, who think they ought to have a bigger merit award than they have got, or if they have not got one, they ought to have one. I do not think I am being slanderous if I say that that is the source of the main opposition, such as it is. But it is the overwhelming opinion of all the constituent bodies of the Joint Committee that the merit award system has justified itself by nine years' trial, and that it had that element of inspiration to which Sir Russell has referred.

494. *Professor Jewkes*: There is just one other point about the merit awards, which I think it would be useful to get help on. When the Spens Report on consultants was being prepared, they were dealing with statistics provided by

Dr. Bradford Hill, and the question had arisen as to how they defined a consultant. Dr. Bradford Hill had employed a certain definition, and as a result of that he found there were, I think, 1,600 consultants in 1938, and when the Spens Committee reported they assumed they were talking about 1,600 consultants. There are now over 7,000 consultants, and the merit award system is, in fact, being applied to a group of consultants nearly five times more numerous than that which, I think, the Spens Committee thought they were dealing with. I do not understand this mystery. I do not understand why there has been this increase in the number of consultants or, indeed, whether it is a right and proper thing to apply merit awards to a much larger group than had originally been envisaged; but if, in the second round of evidence, you have any comments on that, I would be grateful.—We would be glad to consider it. One partial answer is that the object of the health service was to make a consultant service available in all parts of the country, and that involved, necessarily, a very considerable expansion in the number of consultants. But one could not completely answer the question, without looking up precisely what Dr. Bradford Hill's definition covered in the past.

495. *Chairman*: It did seem to us on the whole that certainly there were more than Spens had envisaged ten years ago.—I think that must be so and of course, not only is it a question of there being more consultants to provide the service, but medicine itself has extended and differentiated still further even in ten years.

496. That leads on to another question that puzzles some of us which you refer to in your paragraph 44, where you refer to Danckwerts. It would seem that during the period, and consistently, there has been a steady increase in the amount paid out under the National Health Service to the hospital doctors, at a greater rate on the whole than that paid out to the general practitioners. Yet it would appear that the general practitioners had a betterment of 100 per cent, and the consultants in the hospital services did not have anything like as much; and they are still apparently as favourably placed financially in relation to the other doctors as the general practitioners, or at least favourably

enough placed to make that branch of the service seem attractive. If you had had a Danckwerts and if you had had a 100 per cent. betterment on everything, including merit awards, it would seem that nobody would remain in general practice at all on financial grounds. That is the sort of conclusion to which we are driven by the figures. Could you clear our minds at all on that?—*Dr. Hill*: When you say "hospitals" do you mean the sum spent in salaries for consultants, or the hospital medical staffs as a whole?

497. I mean primarily the consultants. It is in fact divided for one year, but not for the whole years; it is £36 million of which £22 million nearly was for consultants alone for the year 1955-56, and £8½ million for S.H.M.O.'s and so on. Broadly speaking, taking the figures throughout the period, there is a steady rise year by year.—*Sir Russell Brain*: I should not like to give a final answer on that without having time to consider it, but I think one answer is surely that this has been in many respects an exceptional time. It has been a time of expansion, the expansion of the health service, of hospital facilities, upgrading hospital facilities, the creation of consultant appointments in hospitals where they did not exist before; all that has gone on. One must take a long-term view, because what we are concerned with is what is happening now, and already we have evidence that the senior registrars and registrars are not coming forward; they are not attracted by the present state of affairs sufficiently to come forward in the way they did. I think we have been passing through ten very exceptional years, and I would like to be able to consider the various factors in some detail before accepting any generalisation about that.

498. I did not expect an answer immediately to that question, but it does seem to us to be a bit of a mystery that one branch of the service had a very much larger betterment than the other given to it as a result of Danckwerts, and that in fact it is the one that did not get such a large betterment that has so far continued rather to attract a growing proportion of the total number of people; not merely part-timers earning a good deal outside, but the actual amount paid from the service.—We would be glad to consider that, but even

that would be only one ground for a betterment; there might be other grounds of equity which were unrelated to the attractiveness of the service.

499. *Sir Hugh Watson*: I do not suppose Sir Russell needs any help in this matter, but he will remember that in 1954 he himself produced a report on the very matter with which we are dealing, in which he said: "The staff side of the Whitley Council is satisfied that a settlement as achieved does in fact restore the balance between consultant and general practitioner remuneration which was upset by the Danckwerts award." You will remember this fairly well?—Yes indeed; we stand by this now.

500. You went into the whole matter and you came to the conclusion at the end of the day that there had been a sort of balance struck between the two sides of the profession?—That is still our view.

501. *Professor Jewkes*: It was on that that we wanted to be a little clearer because at first glance at the figures this is what happened. The Danckwerts award gave a 100 per cent. addition to the general practitioner, and the award in favour of the consultants—in 1954 I think it was—only gave you a 30 or 40 per cent. increase. How can a 30 or 40 per cent. increase in the case of consultants maintain your balance as against the general practitioner?—*Mr. Sellors*: Going to the negotiations with the Ministry right back to the beginning of the service, I think the evolution of this was as follows. When we entered the service I think it was agreed generally that the general practitioners were at a considerable disadvantage in comparison with the hospital service, and they went forward on the Danckwerts appeal on the basis of full support from us and from every branch of the profession. But Danckwerts, although it was 100 per cent., was reduced to some extent by the great increase of practitioners who had come into the pool. So, whereas the individual general practitioner looked as if he was getting a very large increase, it was actually scaled down proportionately by a certain figure.

502. *Chairman*: Danckwerts was doing only one thing, and that was giving his personal interpretation of what was known as betterment?—And that had to apply to the general practitioner too.

—*Dr. Hill*: On the lines of what Mr. Sellors has just said, Mr. Justice Danckwerts gave that adjudication, but then it had to be negotiated as part of the increased payment for general practitioners, and the general practitioners agreed with the Minister that they would accept the Danckwerts result, associated with a redistribution of panel patients so that the maximum number of patients was reduced from something like 4,000 per list to 3,500 or something like that. It meant in practice the increased income the general practitioner got on the average was very much less than 100 per cent. because he had to accept his smaller list. It came down I think to an average increase of somewhat less than 70 per cent. of his actual income.

503. *Professor Jewkes*: This is a point clearly on which there is a difference of opinion. My own idea on this at the moment would be that under the methods of payment if the number of general practitioners increases then the central pool increases. So, as a result of Danckwerts, the average payment to doctors increased by 100 per cent.; although of course certain people who had lists larger than those which would now be permitted did not get the full advantage of it. But if some did not get the full advantage others must have got more than the average. On the average general practitioners went up 100 per cent., whereas consultants have only gone up 30 or 40 per cent. This seemed to me to be an inequity that I would like your comments on.—*Mr. Sellors*: There was a difference in date of negotiation. The general practitioner was at 1939, and the hospital staff negotiated in 1948.—*Dr. Cameron*: I think there was a certain amount of back deficit due to the general practitioner which was not due to us.—*Dr. Hill*: I think the other point that helps to straighten this out is this: that the consultants obtained quite a distinct betterment factor in their terms of service in 1949. I think the actual net betterment was something like 11 per cent. if you do not include the superannuation contributions from the employer; if you do include that it was about 20 per cent.; whereas the general practitioner was on his pre-NATIONAL HEALTH SERVICE capitation fee until 1951 at the time of the Danckwerts award. In other words, we had already got a bit of betterment before the Danckwerts award.

504. *Chairman*: You got betterment in terms of a change in the value of money?—Yes. For example, Spens in 1949 recommended the basic salary for a consultant of £2,500, and in 1949 we got £2,750. We got that element of betterment. That is the maximum basic salary of a whole-time consultant in 1948.—*Sir Russell Brain*: I am not quite sure whether Sir Hugh's point was to ask us why we did not get more in 1954?

505. *Sir Hugh Watson*: No Sir, you answered my question exactly as I thought you would; namely, that as a result of your negotiations in 1954 you pretty well came to the conclusion that you had put consultants and general practitioners on a parity?—Yes.

506. Maintaining their respective positions financially?—That is so; we have accepted that position still.

507. *Professor Jewkes*: My question is, why did you not get more in 1954. If you take the Spens suggested pre-war figure and your present figure for consultants either at the beginning or end of the scale, clearly it has gone up, I have not the exact figure in front of me, between 30 and 40 per cent. Everybody knows general prices have gone up say 160 per cent. Under these circumstances it is a mystery to me how you can feel that the Spens Report in your case has been implemented?—We do not; we had to accept what we could get; we were at a great disadvantage. If we had gone in with the general practitioners to Mr. Justice Danckwerts we would presumably have got a similar award, but we did not, and after that the government announced they did not propose to apply the Danckwerts award to us, and we were negotiating under duress in fact.

508. *Chairman*: Despite the fact that you got in 1954 a good deal less than you think you would have got if you had had an exact Danckwerts, the balance you feel has been restored. To put you in line with what the general practitioners were awarded by Mr. Justice Danckwerts you did not need as much as he gave them; otherwise, if there had been anything from Mr. Justice Danckwerts, you would have been ahead?—I think we would have said, taking into account all the circumstances at the time, we thought the wise thing to do was to accept that sum and

to stabilise the position vis-à-vis the general practitioners in relation to recruitment, which was the only factor the government would recognise at the time. Taking into account all the factors, we thought that was the best thing to do and we have worked on that basis ever since.—*Dr. Cameron*: I think that point should be emphasised. It was stated to us at the time that the government were not prepared to take into consideration other factors, and they specified betterment and rise in the cost of living. It was as it would affect recruitment, and we appreciated you could only get a certain amount of juice out of an orange; I think that was our attitude.

509. But, despite the fact that you only got a certain amount of juice out of the government, you think that the balance is now restored between the two sides of the profession, if I understand you aright; or you thought so in 1954?—*Sir Russell Brain*: We have accepted that as a basis from then on.

510. And you still do?—Yes, we still do.

511. You may want to give a little bit more thought to this question?—No, no; that is the foundation of our second memorandum.

512. *Professor Jewkes*: And, if in 1950 the consultants had been discussed under the Danckwerts award and the same grant of 100 per cent. increase had been given to consultants, you would have thought that was improperly generous, would you?—We would have thought it was what we were entitled to under Spens.

513. *Sir Hugh Watson*: May I quote you again, Sir Russell? "Apart from the fact that a claim of this magnitude would be totally unacceptable, the effect would be again to upset the balance of remuneration between the two parts of the profession" because your consultant already got £3,000 rising automatically to £5,000, and a consultant holding a top merit award would with Danckwerts get about £10,000?—Yes, I said taking into account all the circumstances, and clearly our relation with our general practitioner colleagues was one of the circumstances which had not been considered at that time. I will not say the past has not influenced us in what we

are going to put to you, if we may, later on.

514. *Professor Jewkes*: Since we have got on to the subject, may I ask what is wrong with the payment of £10,000 to a consultant? You seem to suggest in this statement that is being read now that £10,000 would be an unthinkable sum, and I cannot understand why?—That was said some little time ago, and I would rather leave it until the Commission has had an opportunity of reading what we have to say about merit awards; and it might be that we should wish to amend that.

515. *Sir David Hughes Parry*. The question of income tax is the next matter, and you raise three issues in paragraphs 45, 46 and 47. The first one is a complaint that there has not been a generous implementation of the factor of expenses allowable to consultants, and you say that that apparently has been narrowly considered and the matter is still sub judice in the Whitley machine. In paragraph 46 again, you deal with the whole-time consultant and his complaint as to not being allowed legitimate expenses free of tax; and then in paragraph 47 you deal with the case of part-time consultants, many of whom have now been shifted from one schedule to the other and, although they have won in the court of first instance, the matter is going on to appeal. Probably you will think that the best way of dealing with that is to give us a full account later of the whole position up to date. We would like to get written evidence on that matter with some concrete examples or some statistics of the sums that are involved. It may be that only small sums are involved, but we want to go into that quite carefully. Have you any comment to make? We do not want to press you; these are technical matters in connection with income tax, and if you are not prepared it would be better if we had full documented evidence from you on this matter.—The second memorandum contains a chapter in which we shall discuss that. We have received from Mr. Fuller a letter suggesting you might ask us about one particular part, that is to say, the question of schedule D and E distinction in the case of part-time consultants. We have a little information about that.

516. What we want is as much information, as much concrete evidence, as you possibly can supply on all three points. Until this matter is taken up with the revenue authorities we do not know what sort of sums are involved; it may be only £10 or £50, it may be £500. Is there anything you would like to say today, or would you rather leave it?—*Mr. Sellers*: I think on the general principle the Commission is well aware of the disadvantages under which the full-time labours, and I presume also the difficulties of saying very much about the transfer of schedules until the case has been decided in the courts. I think it is quite clear on which side we stand in that matter.

517. And on the other matter you do not know yet whether it has gone through the Whitley machine?—The other matter of the travelling expenses?

518. Yes.—No, that is still waiting to go through the Whitley machine; it has been under discussion for some time and it may come to fruition quite soon.

Sir David Hughes Parry: I think, Chairman, we had better leave those in the circumstances.

Chairman: Yes, we will do that.

519. *Mr. Watson*: As Sir David said it would be very helpful for the Commission to know just how the absence of these things hits the pocket of half a dozen typical part-timers and half a dozen typical full-timers.—*Sir Russell Brain*: We will do our best to supply that.—*Mr. Sellers*: Would typical examples satisfy you?

520. *Sir David Hughes Parry*: We do not want extreme cases. The next point is on paragraph 59, the operation of the Whitley Councils, and how they have not quite been working as you thought at one time they might work. Do you wish to enlarge upon that?—*Sir Russell Brain*: Here again I think we would rather look at this against the general background of what we suggest in relation to negotiating machinery and the highest level determination of remuneration. It does come very much into that, and we have a section again in the next memorandum on negotiating machinery which fully discusses the Whitley machinery, and we would rather prefer that you should have read that before we discuss what is one facet of the question.

521. Will you deal also with the matter which you refer to in paragraph 65—some form of high-level review organisation?—Yes, we have made specific proposals about that.

522. We were proposing to ask you to give us some assistance on that.—Yes, we have in our second memorandum dealt fully with that, and with the Whitley machinery.

523. I think we ought to read that before asking any questions on it.—I think it would be better, yes.

Chairman: That leaves on one side the whole of the last section of your report until next time.

524. *Professor Jewkes:* I have just one question of fact. In paragraph 23 of your evidence you say:—

"It can be said, however, that the volume of private practice as a whole is substantially less than before the service came in. . . ."

This seems to be contradictory to some other evidence we have had, and I wonder whether you could provide us with any concrete information? Does it mean that there is less private practice for consultants now than before 1948?—Yes, that is our belief.

525. One of the points we would be interested in is what has happened since 1948. Is private practice on the increase? It is still on the decrease?—Yes, I see.

526. I am thinking of private practice by consultants.—*Dr. Cameron:* I would say it would have to be considered in the light of the specialty. It has not decreased to any great extent in certain places in pure medicine. On the other hand in surgery, obstetrics and gynaecology, and especially in the more narrow branches of such things, I should say there has been a very great decline.—*Sir Russell Brain:* In general I think it is true that many patients now, an increasing number, come as out-patients who would previously have gone to private consulting rooms, or, having been in hospital, subsequently attend as out-patients. I am sure that is likely to be a growing tendency as out-patient amenities, appointment systems and so on, become better organised and more widespread.

527. And this is despite the growth of the various voluntary insurance schemes?—Yes, I think probably the

voluntary insurance schemes deal more with the more expensive items like hospital treatment, private bed treatment, operations and things. I do not know how much difference they have made to the level of the ordinary practice; I think we would have to get evidence about that; we could get evidence in detail.

528. Any evidence you could give us would be very useful.—Such evidence as to what provident schemes paid out for particular purposes; that could be obtained.

529. That throws a direct light on private practice?—On one aspect of it, yes.

Professor Jewkes: That would be very useful.

530. *Mr. McIntosh:* In so far as you do represent the dental consultants as well, would you say that the scarcity of consultant posts for dentists, which dentists claim is the case and which you no doubt will also, appears as part of the general scarcity, or are there special factors obtaining there?—I doubt if any of us could answer that without special information.

531. *Chairman:* But we should look to you on your next visit to say if there are special points with regard to dentists?—Yes, if we might have notice I think we shall be very glad to deal with that.

532. Since they asked us to accept your evidence as being in all material respects equally applicable?—Yes, I think we might perhaps bring a dental colleague with us on a subsequent occasion to deal with these points.

533. That would be quite acceptable to us. The Spens Reports dealt with both, did they not?—Yes.

Mr. McIntosh: There was a special Spens Report.

534. *Mr. Gunlake:* May I ask one more question on merit awards; it is supplementary to Mr. Watson's question. Mr. Watson asked whether in your opinion it would be damaging to medicine if the whole system of merit awards were terminated, and you said yes. Could you tell us why? Would you say, for instance, it would be severely and gravely damaging to medicine? If I may help you, would it diminish recruitment to the medical profession as a whole, and the consultant branch in particular? Would it take the heart out of progres-

sive and research medicine? Would it affect the number of recruits into the health service? Could you elaborate your answer?—It is very difficult to answer a hypothetical question. Clearly a lot of people go into the service because they like it, it is their life, and they would continue to go into the service even though their actual remuneration was somewhat less than it is; I think we must recognise that, and that applies to many doctors. But by and large I would have thought if you diminished the financial attractiveness of a profession in competition with others—and we know how much competition there is today by many other spheres for the kind of people who go into medicine—I think inevitably the number and quality of recruits will fall; I do not think I could put it more precisely than that.

535. *Mr. Watson*: Could it not be done by increasing the salary and giving it to the post rather than to the man?—*Dr. Cameron*: It means scrambling for the post, and the man is not looking for where he can do the best work but where his best advantage is. It is just as in the army; you will remember how the regular officer was constantly scanning the Army List to see whether it would be better to stay in the clinical line or go into the administrative line. You would constantly be hearing them say—"I hear So-and-So has got TB; he will not last long!"—*Sir Russell Brain*: One could say quite easily that a senior consultant at a certain level should be paid a certain substantial salary higher than the others. I think it is hard to say how you could ever select 4 per cent. of the posts in the consultant service for particular recognition. I think that is quite impractical. So in effect if you spread the merit awards on some basis of seniority what you would be saying is that no-one in medicine could compete with certain other professions or branches of industry in regard to top level remuneration, and that I think would have a bad effect.

536. Is there not a disadvantage in applying the merit award to the man irrespective of what job he undertakes?—I do not think so; I think it is possible with all the available information to form a very sound estimate of a man's achievements.

537. *Chairman*: Could you say in fact from your knowledge that you think

there is a very wide difference between the people who get the merit awards and those who would get them if it were done on a basis of responsibility or seniority?—I am not quite sure I follow that.

538. The present system does not include allocating anything to the post; in fact, are the people getting the top merit awards usually to be found in the posts of greatest responsibility?—That is a question I would rather you put to the people responsible for the allotment of merit awards, because naturally none of us without special knowledge could answer it. I think personally it would be better if someone connected with the merit awards were to answer that.

539. Someone with special knowledge?—*Dr. Hill*: If I may make two comments upon what Mr. Watson says. The whole philosophy of the merit award was that it was meant to be personal to the man, and it was specifically designed—and I know Sir Russell can confirm this—so that a man should be looked at from his earliest days as a consultant to his oldest days. If he turned out to be a man of great distinction and brilliance and achievement during his first few years as a consultant he might achieve, even during those first few years, the highest merit award. The whole idea was to get out of the consultant service any dangerous element of uniform mediocrity. You must remember it is not easy to differentiate between posts. They really carry much the same responsibility. Only in a few specific posts in the consultant service is the man given administrative charge of the department; otherwise his responsibilities are the same everywhere. There is already practically a ten year span between his beginning salary and his maximum basic salary to account for seniority, and we have always felt that is quite enough, ten years increase steadily for seniority. But the merit award can apply from his very first day of appointment as consultant to his last, and we have always welcomed the philosophy of it as attempting to pick out individual distinction and merit by a committee of authoritative persons. It is this philosophy that we welcome. We dread the idea of a uniform mediocrity in which the remuneration is solely related to a post. I should add one final point; this is not absolutely new. You will find if you look up what was admitted to be one of the most pro-

gressive local authority services before the war, namely the Middlesex County Council hospital service. They had—it was admittedly fairly modest—a definite merit award system; a whole-time consultant's salary might be at any time during his career increased by £200 a year for personal distinction.—*Dr. Cameron*: One other point I think is that the merit award is for clinical merit. The responsibility, clinical responsibility, is equal for all consultants. Any difference as regards responsibility and charge is an administrative responsibility, and the merit award is not for administrative work, it is solely for clinical work.

540. There is one other question on this that I must ask. The basis of the merit award was the Spens recommendation which said—"A method of differentiation involving a selection of individuals of outstanding professional ability". Those are I think the material words. As far as we can gather, some think like two-thirds of all the consultants are therefore regarded as of outstanding ability?—*Mr. Sellors*: No, Sir, only one-third.

541. One-third at any one time, but during the course of their career something like two-thirds of them come to be regarded as of outstanding ability. It may be that the phraseology is wrong; "outstanding ability" is perhaps interpreting it rather widely?—*Sir Russell Brain*: I think one must interpret Spens' words in terms of fractions; he did in fact select the fractions. That, I take it, must indicate what he has in mind.

542. I was asking whether two-thirds of all the consultants are, at some time in their career, of outstanding ability?—May I say worthy of special recognition in varying degree.

Chairman: It is in recognition of special contributions to medicine, exceptional ability or outstanding work—that is how it is summarised.

543. *Sir David Hughes Parry*: He did suggest the fraction. It was one-third of 1,800, and now it is one-third of pre-

sumably 7,000 and although it is a fraction still, and the same fraction, it does make a difference, does it not? One-third of 7,000 is quite different from one-third of 1,800?—It is a point we were going to look into, but unless the quality of the 7,000 has deteriorated the logic would still seem to apply.

544. You have been complaining that the right quality has not been attracted. It could very well be that you could get 1,800 really top class persons, but it would be much more difficult to get 7,000?—I do not remember saying that.

545. *Chairman*: I think we would like you to give a little thought to this, if you would?—We should be very glad to.

546. And perhaps you might care to look at the wording of what originally led to this?—Yes.

547. *Mr. Gunlake*: Your view, as I understand it, would be broadly this, that a monetary award system which is keyed to posts and responsibility might be applicable in the case of a hierarchy of command or fixed establishment; but it is improper for the development of a science, and particularly the development of a science which is of the highest importance in the interests of humanity?—Yes, and one in which the cultivation of individuality and individual talent is of such importance.

548. *Chairman*: There is nothing more you want to say at this time?—No thank you, Sir. We will take away these points you have raised.

549. *Chairman*: We shall look forward to receiving your further evidence shortly and hearing other facts a little bit later.—Yes, I think it would be best if we now completed our second memorandum and sent that to you without trying to amend it, and then we can deal with the points you have raised today in a later communication. I think that would save time.

Chairman: Thank you very much.

(The Witnesses withdrew.)

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HER MAJESTY'S STATIONERY OFFICE

Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

3—4

Third and Fourth Days

Thursday, 16th January, 1958

Friday, 17th January, 1958

WITNESSES

Medical Practitioners' Union

Lord Moran of Manton

LONDON

HER MAJESTY'S STATIONERY OFFICE

1958

FIVE SHILLINGS NET

Witnesses

MEDICAL PRACTITIONERS' UNION

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

THIRD DAY

Thursday, 16th January, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MRS. K. M. C. BAXTER

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

PROFESSOR JOHN JEWKES, C.B.E.

MR. I. D. MCINTOSH, M.A.

SIR DAVID HUGHES PARRY, Q.C.

SIR HUGH WATSON, D.K.S.

MR. S. WATSON, C.B.E.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

Preliminary Evidence on the Remuneration of General Practitioners in the National Health Service presented to The Royal Commission on Doctors' and Dentists' Remuneration by the Medical Practitioners' Union

1. The Medical Practitioners' Union is a national organisation of medical men and women. It was established in 1914 and numbers among its members some 4,000 general practitioners. It is not known exactly how many of these are women. The Union publishes three periodicals—(1) The "MEDICAL WORLD", The Journal of General Practice, which is an independent periodical concerned with clinical and medico-literary matters. It does not deal with medico-political affairs nor does it put forward the views of the Union in its leader section. (2) The "MEDICAL WORLD NEWSLETTER"—sent out every month to 25,000 general practitioners and assistants. It contains articles of interest to general practitioners written from a number of viewpoints. Its leader section puts forward in general terms the Union's views on medico-political matters. (3) The "M.P.U. INTELLIGENCE"—the official organ of the Medical Practitioners' Union, and sent to all members of the Union. It appears at approximately quarterly intervals.

2. The Union proposes to offer full evidence as soon as possible on the remuneration of all medical men and women employed in the National Health Service. This will deal with the amount of remuneration which the Union believes they should receive, with the desirable spread of incomes and with the relationship between the remuneration of doctors working in the hospitals and general practitioners. The Union thinks, however, that the Royal Commission might be helped by a preliminary analysis of the structure of general practitioner remuneration. From this analysis certain conclusions emerge as to the scope and nature of the problems involved. The Union would prefer at this stage to suggest to the Royal Commission the broad lines along which a balanced structure of general practitioner remuneration might be formed rather than to present detailed proposals.

HISTORICAL SUMMARY

3. Before the First World War the general practitioner depended for his livelihood on private or contract fees. The poorer members of society often looked to the out-patient departments of the hospitals and to the dispensaries for treatment because of their inability to find the money to pay a doctor privately. The 1911 Government

introduced the National Health Insurance Scheme to provide the breadwinners of the poorer families with financial help in adversity and with the services of a family doctor. The capitation system of payment was chosen partly for its convenience and partly because *it was thought to protect the doctor against improper pressure for certificates.* During the two decades between the wars this insurance scheme was extended to cover a wider range of workers but their dependents still had to find medical fees privately, rely on the charity of the hospitals, or join one of the many privately organised insurance schemes set up to finance the cost of illness. After the publication of the Beveridge Report in 1942 it became clear that, whatever government was returned to power, a comprehensive National Health Scheme would be introduced. The Labour Government, on assuming office in 1945, announced its intention to introduce such a service. It also set up the Spens Committee on General Practitioner Remuneration to consider "*What ought to be the range of total professional income of a registered medical practitioner in any publicly organised service of general practice.*"

THE SPENS COMMITTEE

4. It is interesting to note in retrospect that the Spens Committee was concerned with ranges of income but not with methods by which these ranges could be assured. "*We are only directly concerned with what remuneration a general practitioner ought to receive, not with the method or basis of his payment.*"

Nevertheless, the Committee had some very pertinent comments to make on the difficulties which would be encountered by a government that tried to implement its recommendations as to the range of income solely by the capitation system of payment. These comments are contained in paragraph 14 of the Report. Had they been noted more closely by the government of the day and by the medical profession and the suggestions made acted on more fully, many of the existing anomalies could have been avoided.

5. The Spens Committee was working in peculiarly difficult circumstances. Nothing was known at the time either as to the method of payment which would be chosen or as to the extent to which the new service would be used by the public. Many observers thought that as much as one-third of the population would continue to pay their doctors privately. Nor could the problems of entry into practice in a new service be considered by the Committee not knowing the circumstances of that service. Lastly, the Committee could have no pre-knowledge of the social revolution that in fact was to take place in the succeeding years. They were asked to look back to a time when income tax was 5s. 0d. in the £, when 2,000,000 of the population were unemployed, when the welfare services were by modern standards rudimentary, in order to form an estimate of the needs of a profession in a world whose shape and climate was as yet unknown. It is not surprising that the results of their enquiries could hardly be very realistic.

6. The Union would deprecate any attempt to base the remuneration of general practitioners for the future on a comparison with a world now 18 years away. The justification for proper levels and methods of remuneration derives from the needs of the profession and the society of to-day and not from the social structure of a past age.

STATEMENTS BY THE GOVERNMENT

7. Nevertheless, the Union would fail in its duty to its members if it did not remind the Royal Commission of the series of statements which were made by the ministers at the time of the passage of the National Health Service Bill through Parliament. These were reiterated by subsequent ministers. They were all to the effect that the livelihood of the medical profession would not be allowed to suffer by the changed circumstances of the new service. The Royal Commission will be aware of many of these statements, which have frequently been quoted (see Appendix "C"). We select one which shows clearly the intention of the Government of the day. These are the words of Mr. Aneurin Bevan, spoken to the doctors shortly before the Health Service came into operation :

"On July 5th we started a new National Health Service. It has been vital to see that it did not carry with it any unfair worsening of a doctor's material livelihood. I sincerely hope and believe that we have secured these things. -If we have not, we can easily put that right. It only remains to wish you all good luck, relief as experience of the scheme grows from your lingering anxieties, and a sense of real professional opportunity."

The Rt. Hon. Aneurin Bevan, July, 1948.

Although the Spens recommendations are not mentioned, the meaning is very clear. The Union believes that after nine years' experience of the Health Service it can be said categorically that there has been "an unfair worsening of a doctor's material livelihood" and that "a sense of real professional opportunity" is still missing from the Service as at present organised.

Although the recommendations of the Spens Committee are only one of the many factors the Royal Commission will consider in making its report, they must remain very relevant to any study of general practitioner remuneration.

WAS SPENS IMPLEMENTED?

8. It is interesting to see how far in fact the Spens recommendations were carried out. Leaving aside for the moment that part of the report that dealt with adjustments to allow for changes in the value of money, the main recommendations are set out below with appropriate comments.

9. The Spens Committee made seven recommendations. The first reads:

"A scheme should be devised which would ensure that between 40 and 50 years of age approximately 50 per cent. of general practitioners receive net incomes of £1,300 or over, and which will also secure, so far as practicable, that between 40 and 50 years of age approximately three-quarters receive net incomes of over £1,000, that approximately one-quarter receive net incomes over £1,600, that slightly less than 10 per cent. receive net incomes over £2,000 and that, in a small proportion of cases, it is possible to obtain net incomes of at least £2,500. By net income we mean gross income less such professional expenses as are allowed by the Inland Revenue for income tax purposes. Here, also, as in the body of the report, we are expressing our recommendations in terms of the 1939 value of money."

Note 1—The above proposal is approximately equivalent to the augmentation of net incomes in 1939 by £200 in the case of incomes between £400 and £1,200, and, in the case of incomes over £1,200, by £200 at £1,200, diminishing progressively to nothing at £2,000.

Note 1b—We say nothing about reducing the high percentage of incomes below £700 since this would follow automatically from the operation of these recommendations."

10. These figures are adjusted below in respect of the betterment factor later applied by Mr. Justice Danckwerts to 1951 and succeeding years.

G.P.s between 40-50 years

Proposed distribution Per cent.	Should earn net (1939 values)	Should earn net (1951 values)
7	Under £700	Under £1,400
20	£700-£1,000	£1,400-£2,000
24	£1,000-£1,300	£2,000-£2,600
24	£1,300-£1,600	£2,600-£3,200
16	£1,600-£2,000	£3,200-£4,000
9	Over £2,000	Over £4,000

11. Have these recommendations been carried out? It is extremely difficult to give the answer, for no figures are available which give the incomes either of individual practitioners or of groups of practitioners. It is possible, however, from certain tables published by the Ministry of Health to form some estimate as to the spread of incomes which has in fact taken place. We reproduce in Appendix "A" tables based on the Ministry's figures. The method of computation is explained in the Appendix. The validity of the conclusions to be drawn depends to some extent on certain assumptions. The Union recognises that these assumptions are only approximately true and the conclusions reached should therefore be accepted with reserve. Nevertheless, it is unlikely that the percentage distribution of income, as shown for all general practitioners in the Health Service, is very wide of the mark. It appears that far too many practitioners (particularly urban practitioners in single-handed practice) are in the lowest earning group, and that there are too few practitioners in the highest earning group. The Union believes that it will be indispensable for the Royal Commission to obtain accurate figures on the present spread of practice incomes. This can be done either by a questionnaire to a representative sample of all practitioners or by collection of information from bodies which provide the practitioners with their incomes. The Ministry of Health is in a position to provide the Royal Commission with a statement of the incomes received by every general practitioner from Local Executive Councils, from Local Health Authorities, from Hospital Management Committees and from other Government departments. These four sources produce at least 97 per cent. of the total income which general practitioners receive. Such information would also reveal the difference in the spread of incomes between English and Scottish practitioners, between different towns and between different types of practice. The Union strongly recommends that this information should be collected and published, for without it the bodies giving evidence and the Royal Commission itself will be without the data on which any firm proposals could be based.

12. The second recommendation reads:

"Before 40 and after 50, practitioners should be remunerated at the rate applicable between 40 and 50 to the burden and responsibilities of practice which they are in fact carrying."

13. This sentence is somewhat vague, but it appears to imply that increasing burdens and responsibilities should be rewarded. This has not been done. No special payment is, in fact, made on account of experience.

14. The third recommendation reads:

"In securing the above results, a method of differentiation of income should be chosen which will command so far as possible the confidence of the profession."

15. It seems doubtful to the Union whether any thought was given to "method of differentiation of income". Neither the Ministry nor the profession appeared willing to examine how far the unmodified capitation system of payment could achieve the spread of incomes advocated by the Spens Committee.

16. The fourth recommendation reads:

"The difference which has existed between the incomes of rural and urban practitioners should be reduced, the Highlands and Islands Scheme should be applied to other sparsely populated areas and the remuneration under that scheme should be increased."

17. The rural G.P. was found to earn (in 1939) £200 more than the urban G.P. (£400 in 1951 terms). Has this difference been reduced? Only tables of general practitioner earnings would reveal the answer to this question. The Highlands and Islands Scheme has not been applied to other sparsely populated areas.

18. The fifth recommendation reads:

"Additional remuneration should be given in areas which prove so unattractive as not to draw an adequate supply of practitioners."

19. This recommendation has been applied only in so far as the new entrant is concerned (initial practice allowance) and, to a very limited extent, by the use of inducement payments.

20. The sixth recommendation reads:

"An adjustment in the method of payment in so far as this depends on capitation should be made in the case of practices involving an altogether abnormal number of aged people and chronic invalids."

21. This recommendation has never been implemented.

22. The seventh recommendation reads:

"On completion of resident hospital appointment a recently qualified practitioner should secure an initial net income of not less than £500 p.a., as an assistant to a doctor in general practice."

23. No steps have been taken to ensure that this recommendation was implemented so far as assistants are concerned. Trainee G.P.s receive less than the sum recommended (adjusted by 100 per cent.).

24. It does not appear that any serious attempt was made to implement the Spens recommendations. All attention was focussed on the net earnings of the "average" G.P. which was found to be £938 by Professor Bradford Hill and which the Spens Committee said should have been £1,111 (in 1939 values).

COULD SPENS HAVE BEEN IMPLEMENTED?

25. Both the Ministry of Health and the profession's representatives seem to have assumed that it was impossible to carry out the recommendations of the Spens Committee for ensuring the proper distribution of money within the profession. It was agreed that a central pool should be created which would provide enough money to pay the "average" practitioner £1,111 plus any betterment agreed upon. In 1948 20 per cent. was added arbitrarily as a betterment figure by the Minister of Health; later this was increased by Mr. Justice Danckwerts to 85 per cent. for 1948 and 1949 and to 100 per cent. for 1950 and 1951. The Spens Committee recommendations were therefore implemented up to 1951 as far as betterment was concerned but in few other respects.

26. The M.P.U. cannot accept that the gross sum provided for by the Spens calculations should be distributed among practitioners in an arbitrary manner, merely following the law of supply and demand. Those who argue that there is nothing objectionable in this method must consider whether the results have brought a fair measure of satisfaction to the majority of general practitioners working in the Service. All our evidence goes to prove that it has not. A few doctors are being rewarded at relatively high rates of remuneration. The majority are, however, suffering from a sense of grievance derived not only from insufficient earnings but from a recognition that the funds available are being distributed in an inequitable manner. We believe we can show that the present method of distributing the gross sum available is not in the best interests either of the profession itself or of the Service.

ANOMALIES OF DISTRIBUTION

Calculating the Pool

27. The first major anomaly connected with distribution of moneys arises from the method of calculating the Pool itself. To do this all sources of general practitioner incomes are lumped together whether they derive from N.H.S. sources or not. Without going into detail, the object is solely to ensure that the "average" general practitioner receives £2,222 p.a.* We have calculated how this affects the "average" practitioner. The only assumption we have made for this purpose is that the "average" G.P. has a list of 2,200 patients. (The average for England is 2,283 [1955] and if Scotland is included the figure is around 2,200.)

* All the figures in this memorandum and in appendices are based on earnings prior to the recent Interim Award.

Analysis of the Remuneration of the "Average" General Practitioner (1955)

	£
Capitation fees and loading	2,370
Temporary residents, I.P.A. and other payments from the Pool	240
Mileage	95
Maternity Services	134
Drugs	85
Training grants	18
Sight testing	4
Hospital Services	68
Local Authority Services	30
Government Departments	36
Private Practice	95
	<hr/>
	3,175
Exchequer superannuation contributions	162
	<hr/>
Total Gross Remuneration	3,337
Less Expenses	1,115
	<hr/>
	£2,222

28. It will be seen from this that the "average" practitioner is assumed to receive his particular share of all the different sources of income available. The first anomaly revealed by this calculation is the impossibility of raising any particular fee except at the expense of the capitation fee or final settlement money. The effect of this arrangement is described more fully later.

Division of Expenses

29. The second anomaly is that which concerns the division of expenses between practitioners. The expense ratio for all practitioners is ascertained from the Income Tax Authorities. The last figure available is 33.4 per cent. This percentage is then assumed to apply to every practitioner. It is, however, well known that the expense ratio varies considerably between different groups of practitioners (single-handed, partnerships; rural, urban, semi-urban). The range probably lies between 50 per cent. and 25 per cent. Some groups of doctors are therefore receiving too little and others too much on account of expenses.

30. The present method of distribution of expenses is also against the public interest since the *individual* practitioner is given a direct incentive to keep his expenses as low as possible in order to increase his net income. This discourages the employment of ancillary staff or improvement of premises. Thus the public is the loser and the efficiency of the Service is undermined.

Variations in the Work Load

31. The Spens Committee was rightly concerned with establishing a proper relationship between the earnings of town and country practitioners. It accepted that certain categories of patients, such as the elderly, require a greater amount of medical care. Surveys which have been carried out since the Service began (see "Good General Practice" by Dr. Stephen Taylor) have shown that the problem of the elderly patient is a small one compared with variations of morbidity between different areas. It has been shown, for instance, that the average patient in South Wales receives approximately eight items of service per annum compared with the three to four items received in the South of England. The average for the whole country is probably about five to six items. It seems to the Union highly anomalous that an elaborate system of differential payments should be devised which takes no account of large variations in work load revealed in these surveys.

No Recognition of Merit

32. One cause of dissatisfaction is that all general practitioners are paid the same rate irrespective of the quality of service they give. No promotion in the general practitioner service is provided for nor any reward for exceptional services rendered.

No Recognition of Experience

33. Many practitioners also feel that it is anomalous that a young man who has been fortunate enough to succeed to a practice vacancy should receive the same remuneration as a middle-aged or older practitioner who has given years of work and has accumulated a store of knowledge available to the Service. When the latter wishes to slacken off as a result of advancing years he must suffer a reduction in income. In most other professions ways are found for rewarding experience and accumulated skills. These are not available in general practice in the N.H.S. as at present organised.

SYSTEMS OF REMUNERATION

34. We have listed above the main anomalies in the present method of general practitioner remuneration and some of the evil consequences which flow from these anomalies. We know that the Royal Commission is not concerned to consider in detail methods of distribution. Nevertheless the Union would maintain that an equitable distribution of available money is nearly as important as the total sum of money involved. Unless some way is found for correcting these anomalies the Union is convinced that dissatisfaction will continue to exist.

35. The Union would now wish to consider in broader terms the whole question of general practitioner remuneration within a public service. Any system of payment should satisfy certain basic requirements. It should encourage doctors to give the best type of service possible to their patients. It should also encourage the right type of young man to enter general practice, provide him with the necessary incentives for good work, a measure of security during his working life and proper and suitable conditions at retirement.

36. There are certain factors inherent in the present organisation of the British National Health Service.

(a) Nearly all doctors in the country must find employment in the National Health Service for few opportunities of alternative whole-time practice exist outside. The State is thus virtually a monopoly employer. The average practitioner depends for his livelihood mainly on his earnings from the Health Service.

(b) It must, however, be recognised that such part-time work outside general practice as requires to be done falls principally to the lot of G.P.s in the N.H.S. for there is no other substantial number of doctors available to do such work. Most of the part-time work in industrial medicine, insurance examinations, local authority clinics, residential institutions and the various medical examinations conducted on behalf of ministries must be done by general practitioners in the N.H.S.

(c) Nearly all G.P.s carry on practice from premises which they either own or are in the process of acquiring. Even if it were considered feasible to provide State-owned premises the transition from private to public ownership would of necessity be a slow one. For years to come, therefore, it can be assumed that most doctors will work from their own premises. This (and the need to man services outside the N.H.S.) pre-determines to a large extent the system of payment of general practitioners. It is difficult to see how a salaried service or a sessional basis of payment (whatever merits they possess) could be applied to a body of men and women working in their own premises and fixing their own hours of work. Unless and until the State is willing to provide a nation-wide chain of health centres and the medical profession is willing to accept employment on a full-time salaried or sessional basis the present method of payment (or some variant of it) must remain the one most suitable to existing circumstances.

It must not be assumed that the Union, in saying this, wishes to prejudge the merits of a salaried service in publicly owned premises.

37. Only two systems of payment, therefore, remain to be considered.

- (a) Payment by item of service, or
- (b) The capitation system or some variant of it.

THE ITEM-OF-SERVICE BASIS OF PAYMENT

38. In countries where medical services are financed through health insurance schemes general practitioners are usually paid on an item-of-service basis. The fees they charge are either determined by a set scale laid down by the State or are left to the judgment of the individual doctors. These fees are then recovered from the State or from the patient direct. In some instances the patient pays the whole fee and recovers some part of it from the State. Usually, only those patients who participate in the insurance scheme are entitled to receive benefit. The advantages of such a scheme are as follows:

- (a) The doctor has a financial inducement to attend his patient frequently.
- (b) The doctor has no incentive to refer his patient unduly often to hospitals because by doing so he loses the fees he would otherwise collect. The tendency, therefore, is to encourage doctors to undertake as many diagnostic and therapeutic procedures as possible within the limits of their training and capacity.
- (c) Under such a scheme there is no differentiation between a private and an insurance patient since the fee charged in each instance is the same. It is only the re-imbursement of the fee by the State which differentiates them.
- (d) It is regarded as an advantage by some for the patient to be able to select which doctor to attend on any occasion.

The disadvantages of the item-of-service basis of payment are as follows:—

- (a) It would be a very complicated scheme to administer in a country where the whole population is at risk. In this country, for instance, 250-300 million separate items of service are given each year. The paper work entailed in accounting for each of these items would be enormous and involve the employment of hosts of civil servants.
- (b) Any such scheme would require the doctors themselves to keep detailed and accurate records of every single item of service given. Not only would it be necessary to have an army of clerks to check all these items but an inspectorate would have to be set up to ensure that all the items were in fact rendered by the doctors concerned.
- (c) The very advantage of encouraging a doctor to undertake as many diagnostic and therapeutic procedures as possible carries with it certain dangers. It is clearly open to abuse in that it may encourage the doctors to undertake unnecessary investigations or work for which they are not technically equipped.
- (d) Payment by item-of-service tends to encourage patients to flit from doctor to doctor and thus lose the advantage of continuity of care.

It does not seem to the Union that an item-of-service basis of payment is suitable in a comprehensive medical service covering every member of the community. The Union cannot agree with a view often expressed that some financial barrier should be interposed between the doctor and the patient, and that if the patient had to meet some part of the cost of treatment he would tend to use the Health Service more wisely. The medical profession has for years maintained that patients should be encouraged to see their doctors before the processes of disease are far advanced. If one leaves to the judgment of the patient the right moment to see his doctor it is inevitable that some will pay the doctor unnecessary visits. But this, the Union believes, is a small price to pay for the additional benefits to the health of the community that result from early visits. In any case the proposal that a patient should pay some part of the cost of treatment at the time of use runs counter to the original conception of a comprehensive National Health Service supported in general terms by the medical profession and by all political parties. It would be a very retrograde step to depart basically from this concept.

THE CAPITATION SYSTEM

39. The chief advantages of the capitation system are as follows:

- (a) It provides a flexible method of rewarding doctors proportionately to the number of patients on their lists.
- (b) It provides remuneration for continuing care of a patient by his own doctor.
- (c) There is no direct financial element in the relationship between the patient and his doctor.

There are, however, some disadvantages. Among these are:

- (a) It offers no financial incentive to the doctor to give the patient the fullest and best service possible. Indeed it may encourage unnecessary reference of patients to hospitals.
- (b) It encourages a "scramble for heads"—a competition for patients which is universally deplored, but seems inevitable where doctors find it difficult to achieve a satisfactory level of income.
- (c) It provides no simple method of entry into practice or of exchange of practices.

A Capitation System inevitable

40. It will be seen from the above analysis that the Union believes that the only practical method of remunerating general practitioners in the British National Health Service at the present time is by a system of capitation. As at present organised, this system has been open to attack—and rightly so, for it contains many anomalies which have led to frustration and a sense of injustice. Since the capitation system is likely to be with us for many years to come it seems to the Union that it is worth taking a great deal of trouble to see that it works as well as possible. Many of the anomalies associated with the system are not inherent in it, but have come into being because of the crude manner in which the capitation system has been applied. While admitting that no possible modifications could remove all the anomalies of the capitation system, the Union holds that many could be lessened, if not entirely removed, by appropriate adjustments. In the succeeding paragraphs we will examine each of the anomalies set out above and suggest methods by which they could be eliminated.

CALCULATING THE CENTRAL POOL

41. The Union would wish to put forward a thesis which it believes fundamental to any consideration of general practitioner remuneration. This is that the task of caring for the health of an average number of National Health Service patients should attract a good rate of pay irrespective of any other work undertaken. If a general practitioner has on his list 2,200 patients (approximately the average number in the United Kingdom) and is providing them with a 24-hour service all the year round, he should receive appropriate remuneration. For this work he at present receives £2,370 gross. If his expenses are reckoned at 33·4% his net remuneration is £1,580 a year. His rate of expenses, in fact, is likely to be higher and is more likely to be in the neighbourhood of £1,000 (42%), leaving him only £1,370 a year net. The Union maintains that this is inadequate remuneration for the responsibilities undertaken.

The work involved in running an average-sized practice must be examined in rather more detail. It is generally agreed that five (or perhaps six) items of service per patient at risk is the average for the country as a whole. Our "average" practitioner therefore has to give 11,000 items of service a year for £1,370 net, or approximately 2s. 6d. per item of service. These five items of service comprise approximately 3½ surgery attendances and 1½ visits. The average net award can therefore be expressed another way. The doctor receives 4s. net per visit and 1s. 10d. per surgery attendance. Similar calculations for the gross remuneration give an average figure of 4s. 4½d. per item of service of 7s. gross per visit and 3s. 3d. gross per surgery attendance.*

* In calculating the above figures no account has been taken of the amount of the final settlement because of its variability. If added it would increase the figures by five to ten per cent.

The general practitioner responsible for his own capital investment and for meeting the expenses of his practice can be properly compared with any other private entrepreneur undertaking the provision of services. We invite the Royal Commission to compare the general practitioner's reward with the fees charged by, say, a radio mechanic or a plumber. We believe that comparisons of this kind will indicate how poorly the general practitioner solely engaged in N.H.S. practice is remunerated for his services.

THE DOCTOR'S RESPONSIBILITIES

42. The unique circumstances of a general practitioner's life must also be taken into consideration in assessing his proper remuneration. Without wishing in any way to exaggerate his difficulties, the Union suggests to the Royal Commission that the following points ought to be given due weight.

- (a) The nature of a general practitioner's work, although interesting, carries tremendous responsibilities. A wrong diagnosis may cost a life. Medical science is not an exact one and inevitably errors occur. Knowing this the conscientious doctor is ever alive to the possibility of error. Yet he cannot foretell when such problems may come his way. His life is one of constant anxiety.
- (b) Due to the nature of disease, the calls upon a doctor's services may be made at any time. Consequently his life is irregular and his household often disorganised. His meals are late and frequently interrupted by fresh calls. Unless he has a deputy, both his evenings and his nights may be disturbed. It is not necessarily the volume of emergency work which weighs on the general practitioner: it is the ever-present possibility of the emergency.
- (c) Many practices are still conducted from the doctor's own residence. His wife and family are a part of the practice, whether they like it or not. The telephone must be answered and messages taken. If the doctor is out he must be contacted. Patients like to chat to the doctor's wife and tell her of their difficulties. These are perhaps small points, but added up and occurring over the years they are a constant source of strain to the doctor and his family. The service rendered by the doctor's wife is an asset to a practice not readily computable in financial terms.
- (d) Unlike the solicitor, the architect or other professional men the doctor has usually to live near or over his practice. Since most of the population live in industrial areas (and some in slums) the doctor must often follow suit. Few members of other professions are handicapped in this way.
- (e) Doctors are at risk through contact with various infections and contagious diseases. There is no compensation paid for any disability or loss arising.

The Union believes that the disadvantages of a general practitioner's life are very real and only partly compensated for by the special interest of his occupation.

N.H.S. WORK A FULL-TIME JOB

43. It may be contended that the calculations involved in arriving at the size of the central pool assume that the practitioner, in fact, receives a considerable amount of income from other sources. This is sometimes the case, but the Union can see no reason why the practitioner who is concerned solely with the care of N.H.S. patients should be underpaid because other doctors are fortunate enough to be able to supplement their incomes from outside sources. The Union therefore recommends that the Royal Commission should, as a first step, decide on the appropriate reward for a practitioner solely engaged in the care of N.H.S. patients. Payment for other medical work should be based on its nature and amount and separately assessed.

44. The present method of calculating the central pool produces another unfortunate result. To determine the size of the global sum, earnings from all sources must be known. In the case of Government departments it is reasonably easy to discover the amount. The trouble has arisen over private practice earnings, which are difficult to ascertain. The elaborate procedure at present followed in

computing the global sum seems to the Union to have no merit apart from the maintenance of the Spens formula. It has one grave disadvantage. Since the global sum is the product of the number of practitioners and the average net remuneration recommended by Mr. Justice Danckwerts it follows that any increase of a payment of one kind must lead to a diminution of another. Thus there is no general advantage in raising any particular fee (such as the maternity fee) because that results only in a lesser sum to be distributed in the final settlement. This procedure would seem to the Union to be the antithesis of good sense. Should it appear to the Government that general practitioners, in the public interest, should be encouraged to do more of a particular type of work (such as hospital duties) it should be possible to appropriate more money for this purpose and to reward initiative of the kind desired without at the same time penalising other practitioners not in a position to undertake these duties. In future, the central pool should be calculated solely in regard to payments for work undertaken in the care of N.H.S. patients. These would comprise capitation fees, loading, initial practice allowances, temporary residents' fees, mileage and a few other small sums. The rate of payment made to the general practitioner from local authority and ministerial sources and for maternity work would be subject to direct negotiation between the profession and the appropriate employer. Such a method would have the advantage of enabling individual work done outside general practice to be encouraged, if it were thought desirable, and proper rates to be determined without affecting the reward received for general practice work in the N.H.S. It would also maintain the concept of a proper rate of pay for the number of practitioners considered necessary to work in the Health Service.

The Royal Commission will note that no mention has been made of the earnings from private practice. These could be entirely neglected if the central pool included only payments for general practice work in the N.H.S.

THE PERMISSIBLE SIZE OF LISTS

45. The Working Party, comprising representatives from the profession and from the Ministry of Health, unanimously agreed in 1952 that the then permitted maximum number of patients allowed to a single-handed practitioner should be reduced from 4,000 to 3,500. This step was taken not only because 4,000 patients was considered too great a number for most practitioners to be responsible for, but because a reduction in the permitted maximum would indirectly help those with the smaller sized lists and achieve a more efficient service. The Union believes that the time has come to make another reduction. The permitted maximum allowed to a single-handed practitioner should be reduced over three years by stages from 3,500 to 3,000. A gradual reduction would allow plenty of time for the necessary adjustments to be made between practices. Doctors would be attracted into those areas where the average list is at present very high, knowing that other practitioners in the area would have to shed a number of their patients during the next few years. *The Union believes that such a recommendation would meet with very wide approval in the profession.*

DIVIDING THE POOL FOR NET REMUNERATION

46. Throughout this preliminary memorandum the Union has avoided making any recommendation with regard to actual levels of remuneration. We have tried to look at the problem of remuneration as a whole and to discuss the principles involved in determining the future structure of medical remuneration in a State Service.

We have recommended that N.H.S. central pool income should be considered separately from other sources and that net remuneration should be divorced from expenses.

We are left therefore with the "net" central pool. Out of this must come capitation fees and loading, temporary resident fees, initial practice allowances and supplementary annual payments. A relatively small sum is required to pay out the last three items mentioned. The remainder would be available for distribution

on a capitation basis. Is there any case for retaining the principle of loading once the practice expenses have been separately paid on a realistic basis? The Union believes that there is. Practice work does not vary arithmetically with the size of the list. A doctor with 3,000 patients has on the average to give three times the number of items of service given by a doctor with 1,000 patients. That is indisputable. But the circumstances are very different. The small-list doctor must remain in his surgery during stated hours, irrespective of the number of patients attending. If he is called to visit 10 patients during the morning he cannot postpone his visits until other patients require a visit in the same areas. The doctor with the full list, having three times as many visits to make, will find many conveniently placed. He may see three or more patients in one street. Certainly he does not cover three times the distance nor take three times as long. The saving in costs is reflected in a lower expense ratio; the saving in time is not. The Union believes, therefore, that a loading should be retained to compensate the doctor with the smaller list for his additional work per patient. The size of the loading in relation to the capitation fee and its appropriate range will be considered in later evidence.

THE PAYMENT OF EXPENSES

47. It is known that the general practitioner uses a third of his gross income to pay for his practice expenses. It is equally known that this figure is an average one and the amount incurred for expenses varies widely according to a number of factors. Some small-list practitioners certainly use 45-50 per cent. of their gross incomes for expenses, while others, with concentrated urban practices, conveniently situated, probably use only one-quarter of their gross incomes. Yet all practitioners are paid on the presumption that a third of their gross income is spent in this way. The present method of distributing money for expenses is clearly inequitable. It penalises the doctor who is trying to build up a practice from small beginnings and helps the long established doctor to a quite unwarranted extent. This is best illustrated by two examples. The doctor with 1,100 patients and a gross income of say £1,650 and with an expense ratio 8 per cent. higher than the average allowed loses £132 p.a. Another doctor with 4,400 patients and a gross income of say £6,600 and with an expense ratio 8 per cent. below the average, gains £528. The introduction of the loading by the Working Party went some way to correct this anomaly but by no means did so completely. The maximum gain given to any practitioner by loading rather than increasing the capitation fee was £200 (to the doctor with 1,500) and the maximum loss incurred by a single-handed practitioner without an assistant (with 3,500 patients) was £200. No practitioners with lists of less than 860 and more than 2,600 gained by the loading system as compared with a flat increase of the capitation rate.

Separation of Net Remuneration from Expenses

48. The Union would like to see net remuneration divorced entirely from expenses. It believes that the central pool should become a central pool for net remuneration, and that a second pool should be created for practice expenses. The method by which the practice expenses pool would be divided should be the subject of close consideration.

Dividing Expenses

49. The present method of distributing the £23 million, which the practitioners as a whole now claim for expenses, has one virtue—simplicity. On all other counts it fails. The expense ratios of practices of different sizes and types vary widely from the "average" of 33.4 per cent. This is well known, yet payments are made on the assumption that the ratio is constant.

Were a separate expenses pool to be created it could be distributed according to the known variations. Even if the rates for each group were not entirely accurate or up-to-date, they would approximate to the actual position more nearly than does the present distribution. The appropriate expense ratios for each group could be ascertained from the Inland Revenue authorities.

This relatively simple modification, however, would achieve rough justice only as between different groups. It would not provide any incentive to the individual to spend money on the improvement of conditions of his practice. The only way to do this would be to repay the doctor his actual individual expenses. This could be done by asking the practitioner to produce a certified return from the income tax authorities each year giving the amount attributable to his practice. The Union proposed this method some years ago.

The direct repayment of individual expenses is undoubtedly the ideal system. A number of obstacles, however, would have to be overcome before such a system would be feasible. Practitioners would need considerable advances against practice expenses before their actual expenses were known. A method would have to be found to determine these advances. Another difficulty would be to ensure that the total paid out conformed to the total declared by all practitioners to the Inland Revenue authorities.

The following tentative scheme is therefore submitted to the Royal Commission for its consideration.

- (a) The total expenses for all practitioners should be ascertained from the Inland Revenue for the last year available. This sum (now approximately £23,000,000) would form the Expenses Pool.
- (b) Accurate expenses ratios for each group would be made known.
- (c) An expenses advance would be made to each general practitioner according to which group he belonged. The advance, however, would not make up the whole amount available. A percentage would be retained for individual distribution.

Example. A single-handed general practitioner with 1,000 patients qualifies—say—for a 42 per cent. expense ratio. He would receive an advance of—say—37 per cent. i.e. 5 per cent. less.

- (d) At the end of the financial year any practitioner who had incurred more expenses than the sum advanced to him would be entitled to submit a claim to his local medical committee. If his expenditure was considered reasonable his claim would be allowed.
- (e) The claim would be submitted in the following manner
 - (i) All expenditure as shown in his income tax return.
 - (ii) All professional revenue, divided into three categories.
 - A. Income from Local Executive Councils.
 - B. Income for salaried or sessional appointments.
 - C. Income from all other sources.

<i>Example.</i>	A.	£2,000	
	B.	£300	
	C.	£700	
			£3,000

Income B is not eligible for expenses and must be excluded from the calculations. Income C is non N.H.S. and would not qualify for expense payments. The expenses allowed for N.H.S. purposes therefore would be 20/27 of the total of expenses declared to the Inland Revenue.

- (f) The total of the claims allowed would be declared by the Local Executive Councils to the Ministry of Health who still would hold the undistributed part of the Expenses Pool—say—£3,000,000. If the claims amounted to £3.5 million they would be met in so far as 6/7 was concerned. Thus the total amount paid out in expenses to practitioners would never exceed the total declared to the Inland Revenue. Indeed the two sums should be the same.

The Union believes that a method of distributing expenses along the lines described above would have great advantages. Each general practitioner would know that his individual circumstances were considered carefully. Doctors would be encouraged to undertake *justifiable* expenditure on their practices. There would be little opportunity of claiming unnecessarily large expenses for there would be a double check—first by the Inland Revenue (as at present) and second by the local committees. No doctor would be forced to submit his practice accounts to scrutiny by a committee; he could accept the expense ratio advanced. Lastly there would be a real incentive to improve the quality of the service given to the public.

CAPITAL EXPENDITURE

50. In most businesses invested capital not only yields a return but is finally recoverable from a possible purchaser. The general practitioner is in rather special circumstances in this respect. He can, of course, sell his motor-car and his medical equipment when he retires, but, unless a medical purchaser is found, money spent on his residence or his separate surgery premises is not so easily recoverable. Indeed expenditure on alterations of residential premises or surgery services may actually diminish the value of the property from a residential point of view. It is difficult to see how this could be corrected or allowed for in any system of remuneration. Nevertheless the Union recognises the hardship suffered by many young doctors who have to raise capital to start in a practice, particularly at the present time when credit restrictions are so severe. It is hoped that the Royal Commission will take these facts into account when assessing the appropriate remuneration of general practitioners. Established doctors are also penalised by their inability to find the capital necessary to convert premises or otherwise improve their practices. The Working Party in 1952 set aside a sum of £100,000 a year to give interest-free loans to those who formed group practices and required money for house purchase, building and equipment. The Union believes that a similar but much larger fund should be created, to give interest-free loans to *all* practitioners needing them for *bona fide* practice purposes. The capital for this purpose should be provided by the State if only to encourage the improvement of the standards of practice for the country. The only loss incurred by the State would be the cost of the interest. The Union hopes that the Royal Commission will give serious consideration to this proposal.

MILEAGE PAYMENTS

51. As far as the differential between town and country practitioners is concerned, the Union recognises the extreme difficulty of devising a mileage system which will please all practitioners or produce an equitable distribution as between town and country practitioners. The present mileage committee has been sitting for the past eight years and has not yet devised a modified system acceptable to all. We can, however, see no prospect of the Royal Commission finding an equitable solution in a short time and we suggest that the mileage committee should continue its work in the hope that some acceptable solution will eventually emerge.

That committee is, of course, concerned with the methods of distribution of the existing mileage fund. It is not concerned with the differential between the earnings of urban and rural practitioners.

The Royal Commission will wish to examine the present position in regard to differentials. Unfortunately, no accurate figures of relative earnings are available to the Union at the present moment. The figures contained in the interim report of the mileage committee would seem to indicate that the present differential is too great.

DIFFERENTIAL MORBIDITY

52. We have drawn attention above to the variable work-load carried by practitioners according to the areas of country in which they live and the rate of morbidity existing in those areas. It would be possible in theory to allocate a higher capitation rate to areas of recognised high morbidity, but we are afraid that such adjustments would be extremely difficult to operate equitably in practice. Nor do we think that it would be possible to devise a differential capitation rate for different classes of patient such as elderly patients and those who are chronically sick, as suggested by the Spens Committee.

Nevertheless the Union would wish if possible to find some solution to the problem of differential morbidity—if only for the extreme cases. Perhaps the difficulties of a special loading of capitation for areas of high morbidity have been overrated. Even if it were not possible to adjust capitation levels to work load in every area of the country, areas of very high morbidity might be held to qualify for a special loading. The Union hopes the Royal Commission will study this question.

RECOGNITION OF EXPERIENCE

53. Experience in the N.H.S. is not rewarded except, perhaps, by the acquisition of a greater list of patients. A middle-aged single-handed practitioner can maintain his income only by continuing to look after a number of patients which he could have coped with easily when younger but not so easily after the age of 50. The Union suggests that it would be possible to correct this anomaly by applying a special capitation rate to practitioners between the ages of 45 and 60. This special rate might vary from one to five shillings per head according to the age of the practitioner. It should only be granted on the first 2,000 patients on a practitioner's list. Thus a practitioner could receive an additional annual sum varying between £100 and £500 according to his age. The special loading would be personal. If such a system were adopted it should not be necessary in a partnership practice to maintain wide differentials as between the partners' shares.

The Union believes that this proposal would be generally welcomed by practitioners. Even those who would not immediately receive it could look forward to an easier life in a few years' time.

PARTNERSHIP AGREEMENTS

54. Before the National Health Service Act an established practitioner who took a young man into partnership received at once a capital sum representing the share of the goodwill bought by the new partner. During the years the junior partner gradually acquired a greater share of the practice by buying more of the goodwill. It was in consequence traditional for him to start with a small share of the practice. Since 1948 the senior partner can derive no immediate benefit from taking a partner into practice. He ought, therefore, to be able to obtain from the Ministry of Health that part of the compensation money appropriate to the share of the practice he has transferred. The medical organisations have pressed this point for many years, but it has not been accepted by the Treasury. The Union would state again that it considers compensation money should be made available for this purpose.

Since the new entrant to a partnership brings no capital with him he is in a poor position to bargain with the established partner and often has to accept conditions which are quite inequitable in order to gain a foothold in the practice. The rules established by the Medical Practices Committee as a safeguard against a hidden sale of goodwill are not necessarily followed in drafting partnership agreements. We know of many instances of junior partners receiving permanently a lesser share of the practice earnings than that to which their work entitles them. The Union can see no justification for the wide variations in earnings between junior and senior partners. It is usual for the junior partner to start off at a share of a third of that of the senior partner. In a partnership of two this means that the junior man is earning one 4th and the senior three 4ths. No one would object to such a provision if the work were equitably shared. But in all too many cases the junior man (who has sometimes been an assistant in the practice for two years) does far more than half the work of the practice and has to wait ten years or more before he receives a parity share. If the Union's suggestion for a length of service payment were accepted it should not be necessary to maintain wide disparities between practice shares. The junior partner should never receive less than a half share of any other partner and parity should be reached in not more than seven years. Partnership agreements should also contain a clause which lays down clearly the approximate amount of work to be done by each partner.

The Union attaches the greatest importance to these recommendations. Nearly two-thirds of all the doctors in the Health Service are now in partnership. An equitable spread of income amongst general practitioners can be achieved only if close attention is paid to partnership agreements. The Union cannot accept the view

that the details of partnership agreements are a private matter if the result of secrecy is to infringe one of the sections of the National Health Service Act. Partnership agreements should have to conform to criteria laid down centrally.

ASSISTANTSHIP

55. Since the introduction of the Health Service most young doctors have become principals following a period of preliminary assistantship. This seems to the Union to be the best method by which a young man can enter practice. Although there will always be a place for the single-handed practitioner, there is little doubt that the future of general practice within the Health Service lies with the partnership and with the group practice. A small number of doctors will succeed to practice vacancies when they occur and an even smaller number will establish themselves single-handed with the help of the initial practice allowance. The common method will inevitably be by assistantship. For this reason it is important that the normal method of entry to practice should be free from possibilities of abuse. We have already dealt with the difficult question of the assistant who becomes a junior partner. We must now examine in detail the preliminary period of assistantship itself. This presents little difficulty when the principal employing the assistant has a genuine intention of taking his assistant (if proved suitable) into partnership at the end of a reasonable trial period—say one year. Unfortunately many assistants are told that they will become partners at the end of a trial period only to find out later that "circumstances have altered" and there is no possibility of their being admitted to the partnership. Over the course of years the Union has had to deal with hundreds of these cases and there are a number of principals who have been known to employ as many as eight assistants since the Health Service came into operation. It may be argued that the assistant should not accept such posts knowing the hazards that attach to them. But it must be remembered that this is now the normal method of entry into practice. The acceptance of a post as an assistant often involves finding living accommodation, making arrangements for children to go to school locally, etc. Assistants should be entitled to know that they will be taken on as partners, providing they do their work properly and are acceptable to their principals. The Royal Commission asks in its questionnaire whether it would be practicable for the profession to establish a fixed scale of payment for assistants in general practice. The Union believes this would be the wrong way of tackling the problem. No national scale could easily take into account the variable circumstances in different parts of the country. Nor would it be desirable for assistants to be permanently employed even at a scale of pay recognised to be equitable. The answer, in the Union's opinion, is to lay down clearly the circumstances which justify the employment of an assistant. The Local Executive Councils should then require any principal employing an assistant to justify his employment.

Justification for Employment of an Assistant

56. There would appear to be three grounds on which a principal could reasonably be entitled to employ an assistant.

- (a) A partnership whose combined list is expanding wishes to take on a new partner. Here the doctors concerned must be given the opportunity to try out a number of assistants in order to select a suitable new partner. The Union believes that a period of two to three years should normally be quite sufficient for this purpose and would enable three or four assistants to be tried out.
- (b) Owing to illness or other temporary circumstances a principal or partnership may wish to employ an assistant for a strictly limited period with no prospect of partnership. This appears to the Union to be a reasonable ground for employing an assistant temporarily and should be allowed.
- (c) The third case really comes under the first category but presents special difficulties. We refer to the single-handed principal who has built up his list to the maximum permitted size and wishes to take a partner. Unless the partnership succeeds in building a much higher combined list the principal concerned will have to accept a serious drop in income for

several years. First, there is the period of trial during which the principal employs an assistant. Here his income drop will be the amount of the assistant's salary (less income tax deductions). When he eventually decides to take the assistant into partnership he will gain an additional loading, so that the cost to him of taking a partner will amount to the assistant's share less the loading.

57. The Union proposes certain modifications in the present arrangements which would meet all the above circumstances.

- (a) The employment of an assistant should be regarded as a temporary measure which should require justification to the Local Executive Council. In all cases the period of assistantship should be limited.
- (b) The Local Executive Council, together with the Local Medical Committee, would examine each request for permission to employ an assistant and judge it on its merits. The normal maximum period allowed for running a practice with an assistant would be three years.
- (c) Hitherto all principals have had to find the money out of their own pockets to pay the assistant. It is true that a sum of between £1½ m. and £2m. is included in the total expenses of all practitioners on account of the employment of assistants. But this sum, like other sums under the heading of expenses, is divided up between all practitioners whether they employ assistants or not. The "average" general practitioner with a list of 2,200 patients receives approximately £95 per annum on account of the employment of an assistant when, in fact he has never employed one. The single-handed practitioner with a maximum permitted list of 5,500 who employs an assistant receives only £237 of his expenses money towards the employment of his assistant. *The Union believes that the principal who is genuinely entitled to employ an assistant and whose need to do so is recognised by the Local Executive Council should be entitled to claim the entire expenses of the assistant for the permitted period.* This money would be paid out of the expenses pool as described above and distributed only to those practitioners who actually employ assistants.

The argument has sometimes been put forward that there are a small number of doctors who never wish to become principals but prefer to spend their lives as salaried assistants. The Executive Councils could make exceptions to the general rule in those cases, where they were convinced of a desire to retain the assistant status.

The Regulations

The Royal Commission will be aware that the N.H.S. regulations have recently been altered so as to require the Local Executive Council, in conjunction with the Local Medical Committee, to review at intervals the right to employ an assistant. This is certainly a move in the right direction. But the Union would still wish to see a time limit placed on the right of any principal to employ a whole-time assistant. As the regulations now stand the Executive Council can withhold the right to employ an assistant or limit the number of patients allowed *solely* on the grounds that the principal is not rendering proper service to those on his list.

Ex-Registrars

The position of the ex-registrar in connection with assistantships requires special consideration. The Union would prefer to postpone comments on this subject until it gives further evidence.

Part-Time Assistants

Nearly all principals must from time to time make temporary arrangements for the conduct of their practice. *Locum tenentes* are normally engaged during periods of illness, holidays, etc. It sometimes happens, however, that a principal wishes to absent himself *regularly* from his practice for certain hours during the week (he may attend a hospital clinic) and must make arrangements for these periods.

He normally employs a neighbouring colleague in practice or a retired doctor as a part-time assistant. The Union wishes to make a clear distinction between part-time and whole-time permanent assistants. There is a proper place for the former, but none for the latter.

ENTRY INTO PRACTICE

58. In 1956, 967 doctors were admitted to the lists of Executive Councils in England and Wales. The manner in which they entered practice is analysed below:

349	admitted as partners in practices where they were previously assistants.
260	admitted as partners, but not previously assistants.
100	formed new practices.
97	succeeded to practice vacancies.
150	took on limited lists.
11	miscellaneous.
967	TOTAL

59. Parliament considered that it was inappropriate for National Health Service practices to be bought and sold as they were before the Act was passed. The decision to abolish the right to buy and sell the goodwill of practices had certain unexpected consequences. Entry into practice has in many ways become more difficult—not less, as anticipated. Before the Act the goodwill of a practice was a readily saleable commodity. This was recognised by banks and insurance companies. The young man who wished to enter practice seldom had much difficulty in borrowing the sums necessary to buy out the retiring doctor. It is true that he often spent many years of his working life carrying a load of debt, but this was eventually paid off and he then found himself in possession of an asset which he could realise on his retirement. This method of entry into practice had another advantage. The new entrant was supplying the cash which the remaining partners in the practice needed. He was therefore in a strong bargaining position to extract an equitable practice contract from them. Now the newcomer has no such asset. He urgently needs to establish himself and often has to accept conditions which may not be so favourable.

60. There are three ways of entering practice. These are:

- By succeeding to a practice vacancy.
- By setting up a new practice with or without the help of an initial practice allowance.
- By joining an established partnership from scratch or after a period of assistantship.

(a) Succession to a Practice Vacancy

Comparatively few practice vacancies occur each year. In 1956 the number was 97. The choice of a successor is an extremely difficult problem. In the south of England over a hundred applicants may apply for a vacancy (the average was 58) and even in the industrial north the number is seldom under thirty. It will be seen from this that many are called but few are chosen. The Union has knowledge of a large number of cases of men of thirty to thirty-five who have applied over and over again but have not succeeded in obtaining a vacancy. Few doctors can afford to wait for years to be chosen for one of these vacancies. In the meanwhile they must work as assistants. Few principals employing an assistant like to feel that their assistant may leave them at any moment on obtaining a practice vacancy.

The system of filling practice vacancies resembles a lottery. The successful applicant may on occasions find himself inheriting a practice far larger than he would ever have contemplated. (There was recently a case where an assistant succeeded to the list of 5,500 patients from his principal who had recently died.) The vast majority of applicants must expect to be disappointed—not once or twice, but many times. The argument in favour of maintaining the present system is the

need where possible to maintain an established practice intact. The Union can see no advantage in altering the workings of the present system although it must be recognised that succession to practice vacancies can never do more than establish a minority of new entrants in practice.

(b) Setting up Practice on One's Own

Only a few doctors in each year (100 in 1956) decide to set up practices on their own, despite the very real financial assistance given by the initial practice allowances. This is at first sight surprising, but the reasons are not far to seek. Few young doctors can find the necessary capital resources to establish themselves. A house and motor-car must be bought and the necessary furniture and equipment acquired without the assured income needed to find the interest and capital repayment charges. This position is especially bad at the present time when the banks are not allowed to give credit unless security is very good. The help provided by the initial practice allowance is very necessary, but it does not suffice to meet all obligations undertaken.

(c) Entering a Partnership

Most doctors now enter practice by joining an established partnership with or without a preliminary period of assistantship. In 1956 63 per cent. entered this way. The advantages are clear. Less risk of failure exists since the practice is already established; it is not usually necessary to acquire and equip new surgery premises; the inexperienced newcomer has the benefit of his partner's knowledge to lean on.

The Union welcomes the trend towards partnership practice. To facilitate entry into an established practice it recommends that the period of preliminary assistantship should be limited and the terms of partnership kept under review.

EXCHANGE OF PRACTICES

61. One of the disabilities connected with the present organisation of general practice is the difficulty of exchanging practices. Before the Act came into operation it was common for doctors to exchange practices. An elderly practitioner who had spent many of his years looking after a large practice would be willing to retire to a small practice in a seaside resort, while a younger man anxious to acquire a larger income would move from that resort to an industrial area. Since 1948 few exchanges have taken place. The main reason is that the abolition of the right to buy and sell the goodwill of a practice has meant that no financial adjustment could be made to allow for the income differences between the two practices. Because of this many doctors have felt immobilised and frustrated. They can see no possibility of leaving their present places of practice.

STATE OF MIND OF GENERAL PRACTITIONERS

62. The Royal Commission asks whether there are any factors other than remuneration which are affecting the contentment of general practitioners. Anyone who has had anything to do with general practitioners since the introduction of the Health Service or has read the columns of the medical press carefully will recognise two recurrent refrains going through the published comments. The first concerns those members of the public who abuse the benefits of a free National Health Service either by visiting the doctor unnecessarily or by asking for home visits when they are not really needed. The second concerns the system of remuneration by capitation. This, it is claimed, provides no incentive to the good general practitioner to give his patients a better service nor to practise higher standards of medicine.

The first complaint is undoubtedly justified to some extent. Before the introduction of the Service there was a section of the public who regarded all medical treatment as a luxury. Now they are entitled to it free of charge at the time of use and there are some, but not many, who abuse this right. To introduce a general financial deterrent in order to prevent this small number misusing the facilities now offered would be a grave mistake. Many practitioners have already succeeded in seeing that abuses are reduced to a minimum. We believe that a process of

education by the practitioner and by the Ministry of Health would soon result in a much more reasonable attitude being taken by this small section of the public. There will always be a tiny minority of patients who will act unreasonably and this must be expected under any system.

The second ground for discontentment is much more difficult to solve. The capitation system allows for recognition of merit only by the attraction of a larger list of patients. Merit is difficult to assess in any walk of life but in medicine it is almost impossible. The Union is convinced that general practitioners would resist strongly any attempt to introduce a system of merit awards. The only method we need contemplate is an extension of item-of-service payment. Maternity services are paid for on this basis. It might be possible to extend this method of payment to special types of work not normally undertaken by general practitioners. We refer to certain minor operations, investigations and psychiatric treatment more elaborate than that usually undertaken. Although theoretically attractive, this proposal would in practice be very difficult to apply. Matters would probably best be left as they are.

The capitation system of payment, like all other systems, has its defects. The Union believes that these could be largely mitigated (though not entirely removed) by modifications of the type suggested in this memorandum.

CONCLUSIONS

63. The Union offers this preliminary memorandum on the remuneration of general practitioners to the Royal Commission.

It recommends that the Royal Commission should :

- (a) ascertain, by whatever means are available to it, the present distribution of money among general practitioners ;
- (b) examine the possibility of basing the future remuneration of general practitioners as a group on the work done in N.H.S. general practice ;
- (c) examine the possibility of separating net remuneration from expenses and of recommending the proper net reward for the practitioner who is solely engaged in caring for N.H.S. patients ;
- (d) consider how best expenses should be paid to practitioners ;
- (e) consider the desirability of reducing the maximum permitted size of lists ;
- (f) examine the desirability of setting up a Capital Expenditure Loans Fund for all practitioners ;
- (g) examine the merits of special loading for doctors with experience ;
- (h) examine the possibility of establishing central criteria for partnership agreements and of registration of these agreements ;
- (i) consider the Union's proposals with regard to the employment of assistants.

In this preliminary memorandum the Medical Practitioners' Union has confined its evidence to an examination of the present structure of general practitioner remuneration. This structure, in the Union's opinion, needs radical overhaul in order to provide a better service to the public and to satisfy the best interests of the medical profession.

When more facts are available regarding the present spread of incomes, the Union intends to put forward specific proposals for the amount and range of general practitioner remuneration.

It also intends to submit full evidence concerning the remuneration of doctors employed in the hospital service.

APPENDIX "A"

1. The Union has tried to ascertain from the information available the present spread of income among practitioners in order to compare it with the spread recommended by the Spens Committee.

2. No figures of G.P. earnings have been published. The only methods available are (a) to use the Ministry of Health figures of doctors with different-sized lists or (b) to ascertain the earnings of doctors from the Inland Revenue.

3. The second method is the more accurate. Unfortunately the last year reviewed was 1952. It is impossible to distinguish between sources of income in the Inland Revenue returns. Unless it is known which group of practitioners earn most from private practice any conclusions derived from a study of these figures may be wrong.

4. The Union has attempted to ascertain the spread of incomes by relating income to the size of list. This was done by means of Table B of Appendix XVIII of the Ministry of Health Report, 1955. The number of doctors with different-sized lists was ascertained and the earnings related to those indicated on Graph "A". The number in each earning range was compared with the recommended Spens spread adjusted by 100 per cent. (being post-Danckwerts).

5. This method is full of pitfalls since it depends on the validity of certain assumptions. These are as follows:

- (a) That the average gross earnings of £3,337 (i.e., £2,222 plus expenses at 33.4 per cent.) was the sum earned by the G.P. with the average list of 2,200.
- (b) That the average of any range lay at the centre point (i.e., in the range 3,001—3,600 all the doctors concerned were assumed to have a list of 3,300).
- (c) That the gross earnings from all sources other than capitation, loading and superannuation varied arithmetically with the size of list.

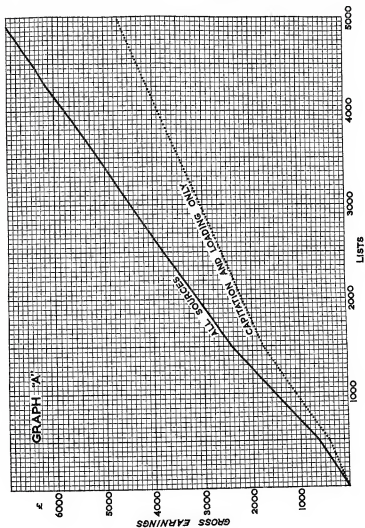
6. It is clear that these assumptions are, at the best, only approximately true. The first assumption is true in so far as it relates to capitation and loadings and superannuation grants (76 per cent.) but not to earnings from other sources (24 per cent.). The second assumption is probably sufficiently correct not to invalidate grossly any conclusions reached. The third assumption is obviously untrue as far as individual doctors are concerned, but may not be too wide of the mark where groups are considered. Substantial earnings from private sources are largely confined to a small number of doctors. One might expect to find some of these doctors among the small-list group which would distort the lower end of the graph.

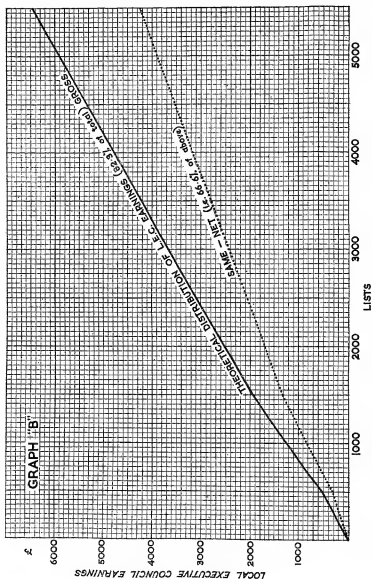
7. The Union therefore presents this table of earnings with reservations as to its accuracy.

THE SPREAD OF GENERAL PRACTITIONER INCOMES
A Comparison with the Spens Recommendation
England and Wales, 1955

Net Earnings in 1951 value of money (Spens spread)	Number of Patients needed to earn these sums	Number of Doctors in Each Earning Range						Spens Recommended Spread				Number of Doctors			
		Urban		Semi-Urban		Rural		Total		Per cent.	Per cent.	All Single-handed (without assistants) (33·4 expense ratio)		Single-handed (without assistants) (Variable expense ratio)	
		Per cent.		Per cent.		Per cent.		Per cent.				Per cent.		Per cent.	
Under £1,400	Under 1,350	1,341	16·5	492	7·7	534	13·1	2,367	12·6	20·0	7·0	1,590	26·7	2,011	33·9
1,400—2,000	1,350—2,000	1,749	21·5	1,404	21·8	1,511	36·9	4,664	24·8	20·0	20·0	1,482	25·0	1,061	17·7
2,000—2,600	2,000—2,580	1,716	21·0	1,705	26·3	1,181	28·8	4,602	24·6	24·0	24·0	1,054	17·6	1,054	17·7
2,600—3,200	2,580—3,250	1,769	21·7	1,756	27·3	662	16·2	4,187	22·3	16·0	16·0	857	14·4	857	14·4
3,200—4,000	3,250—4,125	1,237	15·2	940	14·5	201	4·9	2,378	12·7	24·0	24·0	939	15·8	939	15·8
Above £4,000	4,125 and over	341	4·1	189	2·4	36	·1	566	3·0	9·0	9·0	27	·5	27	·5
TOTALS		8,153	100·0	6,486	100·0	4,125	100·0	18,764	100·0			5,949	100·0	5,949	100·0

Doctors represented by
partnership of more than
six (not included) 19
TOTAL AS AT 1st JULY, 1955 18,783





APPENDIX "B"

1. Below are reproduced two tables of G.P.s' earnings from the recently published 1957 report of the City of Glasgow Executive Council.

The following shows the grouping of numbers on doctors' lists:—

Doctors with no persons on list	...	...	...	...	...	9
" " lists of 1 — 100	...	...	...	...	...	105
" " " " 101 — 500	...	...	...	...	...	86
" " " " 501 — 1,000	...	...	...	...	...	64
" " " " 1,001 — 1,500	...	...	...	...	...	75
" " " " 1,501 — 2,000	...	...	...	...	...	89
" " " " 2,001 — 2,500	...	...	...	...	...	86
" " " " 2,501 — 3,000	...	...	...	...	...	59
" " " " 3,001 — 3,500	...	...	...	...	...	52
" " " " 3,501 — 4,000	...	...	...	...	...	24
" " " " 4,001 — 4,500	...	...	...	...	...	23
" " " " 4,501 — 5,000	...	...	...	...	...	9
" " " " 5,001 — 5,500	...	...	...	...	...	2
						<hr/> 683 <hr/>

The following table shows the grouping of gross remuneration of doctors with Glasgow reference numbers:—

					56/57	55/56
No. of doctors earning					Nil	...
" " " " up to	£500 p.a.				...	2
" " " " from	£501 — £1,000 p.a.				...	75
" " " " " " " "	£1,001 — £1,500 p.a.				...	51
" " " " " " " "	£1,501 — £2,000 p.a.				...	48
" " " " " " " "	£2,001 — £2,500 p.a.				...	64
" " " " " " " "	£2,501 — £3,000 p.a.				...	72
" " " " " " " "	£3,001 — £3,500 p.a.				...	77
" " " " " " " "	£3,501 — £4,000 p.a.				...	62
" " " " " " " "	£4,001 — £4,500 p.a.				...	41
" " " " " " " "	£4,501 — £5,000 p.a.				...	34
" " " " " " " "	£5,001 — £5,500 p.a.				...	22
" " " " " " " "	£5,501 — £6,000 p.a.				...	19
" " " " " " " "	£6,001 — £6,500 p.a.				...	5
" " " " " " " "					...	1
					<hr/> 572 <hr/>	<hr/> 575 <hr/>

2. There is no way of correlating earnings with the size of list in the above tables. Nevertheless certain interesting conclusions emerge from the figures.

It appears from the first table that in the City of Glasgow (including apparently doctors from adjacent areas on the Glasgow list) 339 doctors had lists of under 1,500 and 344 had larger lists. Approximately half the Glasgow doctors had, therefore, incomes from L.E.C. sources of £1,330 net or less (see Graph "B"); or, if only capitation and loading are considered, £1,180.

If the second table is considered, we calculate that more than half the Glasgow doctors had as earnings, on the average, £1,260 (312 doctors or 54·6 per cent.); 260 doctors (45·4 per cent.) had average earnings of £3,900. Both figures are *gross*. The net figures for the two groups are £838 and £2,596.

3. In the same report the following sentences occur :

" Having regard to the number of medical practitioners on the list, the average paid to a practitioner for capitation fees and loadings amounted to £1,682 13s. (£1,661 12s.).

" The average payment for capitation fees and loadings to practitioners excluding those resident outwith the City amounted to £2,032 19s. (£2,021 3s.).

" The Council made payment on the 31st December of a supplementary sum notified by the Department of Health in settlement of the year 1954/55. The sum disbursed to the practitioners involved was £96,327 11s. 5d. . . .

" The average payment to practitioners for capitation and loadings, including the supplementary sum mentioned above, and excluding practitioners resident outwith the City, amounted to £2,202 18s. 0d."

Deducting 33·4 per cent. for expenses, the average net remuneration from L.E.C. sources, including the final settlement, is £1,465.

4. Few Executive Councils publish figures of earnings. The Glasgow figures, unless substantially modified by earnings from other sources, would appear to suggest that there are far too many doctors in the lower earning range.

It is however pointed out that the average payments to practitioners quoted above excludes payments from other adjacent local Executive Councils. This may to some extent vitiate the conclusions reached.

APPENDIX "C"

The Family Doctor and the Health Service, a pamphlet recently published by the Medical Practitioners' Union, sets out the history of the dispute over doctors' pay and presents it in a social framework.

Additional Memorandum of Evidence by the Medical Practitioners' Union Explanatory Memorandum on the Repayment of Expenses of General Practitioners

1. *The Union* has always objected to the present method of paying expenses to general practitioners for the following reasons :—

- (a) It is inequitable because the payments made are not related to the actual expenses incurred.
- (b) It discourages the practitioner from spending money on the employment of ancillary staff and the improvement of his practice.
- (c) Conversely it enables those practitioners who are in a position to run their practices cheaply to increase their net incomes at the expense of practitioners who are less fortunately placed.

2. *The Union* has suggested three schemes for dealing with this problem. The first was proposed in November, 1950, and made the following suggestions as far as expenses were concerned :—

- (a) That all practitioners with lists of less than 1,000 patients should receive £600 per annum on account of expenses and £25 per annum extra for every additional 250 patients up to a maximum of 3,000 patients.
- (b) That the additional sums incurred on account of expenses by all practitioners taken together (as ascertained from the income tax authorities) should be added to the capitation fee.

- (c) That practitioners would continue to receive income tax relief on any legitimate expenses incurred.
- (d) That the payments mentioned above would be paid automatically in the case of all practitioners with over 1,000 patients, but that established practitioners with smaller lists would have to justify their claim to an expense allowance to a central committee.

Comment :

These proposals were designed in effect to give a basic salary to practitioners which represented approximately the level of their expenses. It was a very rough and ready suggestion and did not substantially correct the anomalies mentioned above.

3. In November, 1951, the Union made new proposals for dealing with expenses. These were as follows:—

- (a) That the Central Pool should be split into two parts, one for net remuneration and one for expenses.
- (b) That net remuneration should be paid as heretofore but at a reduced level (i.e. approximately $\frac{2}{3}$ of the existing rate), and that expenses would be repaid on the basis of actual expenses incurred. The scheme would operate as follows:—

i. Each N.H.S. practitioner would obtain from his accountant a statement of the amount of his gross practice receipts from (1) Local Executive Councils and (2) Private Practice. Other sources of medical income would be ignored (Medical Board Insurance Examinations, etc.).

ii. Each practitioner would submit to a Claims Committee of the L.E.C. an annual statement of his *total* practice expenses.

iii. He would be repaid that proportion of his claims applicable to N.H.S. work.

Example :

	£
Claim for practice expenses	950
Income from L.E.C.	2,000
Income from private practice	500
80 per cent. claim repaid	760

iv. For income tax purposes the amount of the claim allowed for N.H.S. purposes (£760 in the above example) would be declared under Practice receipts, and the *actual* expenses incurred (not necessarily the same amount) would be entered as at present.

v. For the first year in practice an approximation of expenses would have to be allowed. The Medical Practices Committee, acting on the advice of the Local Executive Councils, must decide in which areas new entrants would be entitled to reimbursement of practice expenses under the M.P.U. scheme.

vi. Since the expenses would be repaid only at the end of the year or later, doctors would be advanced their expenses up to 90 per cent. of the previous year's claims and a final adjustment would be made each year.

vii. Partners would submit individual claims for expenses. The sums received would constitute practice receipts and would presumably be pooled and redivided according to the partnership agreement in force.

viii. The type of claims form which might be used is included on Appendix "A".

Comment :

These proposals appeared to correct all the anomalies in the existing system. Each practitioner would, in fact, receive back from the Government the full amount of all expenses incurred. There was, however, one basic objection to

the scheme; it appeared to encourage doctors to spend substantially more than they were spending before. In so far as the majority of expenses were concerned, this objection was not valid because it could be assumed that practitioners, advised by their accountants, were already claiming their full entitlement of expenses. The income tax authorities would not be likely to accept substantially higher expenses for the same-sized practice. Nevertheless there were certain categories of expenses where some check would be necessary and it was proposed for these items that prior authorisation would have to be received from the local claims committee. The Union still believes that these proposals are basically sound and could be implemented providing the proposed safeguards were introduced.

4. In presenting evidence to the Royal Commission the Council of the Union tried to devise a practical scheme which, in fact, was a compromise between the proposals made in 1951 and the present method of repaying practice expenses. The Secretary of the Royal Commission has indicated certain difficulties which could be foreseen in implementing such a scheme. These are set out below, with the Union's comments.

- (a) "It would surely be necessary to withhold a much higher proportion of the "normal" expenses than is proposed in the example because the range of expenses would presumably vary fairly widely even within the groups."

The Union suggested that an advance should be made to each practitioner according to the category of practice in which he worked. If, for instance, the average expense ratio for single-handed rural practitioners was 42 per cent., it was proposed to advance up to 37 per cent. to any practitioners in this category. One would, in effect, be retaining about 12-15 per cent. of the expenses pool for later distribution. The Union agrees that the sum might not be sufficient to meet the subsequent claims, but there is no evidence to enable a more accurate estimate to be made. The exact amount of the advance is not material to the basic principles of the claim proposed.

- (b) "The scheme involves possible conflict between the Inland Revenue and the Executive Council in that expenditure approved for Inland Revenue may not be approved for the Executive Council. The criteria to be applied by each are not defined."

The Union can see no reason for conflict between the Inland Revenue and the Executive Council. It does not appear necessary that the amount of the claims agreed by the Inland Revenue should necessarily be the sum repaid to the individual practitioner. Indeed, if such conflict is considered to exist any practitioner to-day who actually incurred an expenses ratio of more than 33.4 per cent. would feel entitled to claim that the Government should pay him the balance. There are many instances in the business world where employees are paid fixed sums annually for their expenses. If the actual expenses are greater they claim these as allowable expenses from the income tax authorities. Since the general practitioner is a self-employed person under contract for services he is entitled to claim from the Inland Revenue that those expenses properly incurred should not be subject to tax. The obligation of the Executive Council to repay a general practitioner's expenses is an entirely separate matter and can be treated on a different basis.

- (c) "It is not at all clear where the Local Medical Committee comes into the picture (though they are brought in in sub-paragraph (d)). Again there is room for conflict between them and the Executive Council."

Those practitioners who consider they can justify a higher rate of expenses than that allowed would be entitled to submit a claim to the Executive Council. This claim would be considered by a joint sub-committee of the Local Executive Council and the Local Medical Committee. It is regretted that this was not more carefully explained in the memorandum.

- (d) "At present the Inland Revenue allow tax relief on all approved professional expenses. The Union scheme proposes that the practitioner should be reimbursed by the Health Service only for that proportion of the expenses which relate to Health Service work. These are normally two different

figures, yet in sub-paragraph (f) the Union say 'Thus the total amount paid out in expenses to practitioners would never exceed the total declared to the Inland Revenue. Indeed the two sums should be the same.'"

At the present time practitioners in submitting their accounts to the Inland Revenue are not called upon to set out in detail the sources of their professional incomes. It would, however, be necessary to do this in future so that the income from the Local Executive Council sources could be separated from other income. It would be difficult for the practitioner, in making his income tax return, to apportion his expenses accurately as between his different sources of income and it would be necessary to assume that the expense ratio incurred for work done for the Local Executive Council was the same as for other types of work. Were all accounts prepared on this basis in future one could determine the global expenses figure which applied to Local Executive Council incomes and it is this figure to which we refer in paragraph 49 (f).

5. *The Union* wishes to state that it is not concerned in detail with the actual mechanics of any scheme for repaying practice expenses. In any case these mechanics would have to be the subject of a detailed study and negotiations between the Ministry of Health and the profession. It is concerned, however, with establishing the principle that the repayment of practice expenses should be divorced from net remuneration and that expenses should be repaid on a realistic basis.

APPENDIX "A"

GENERAL PRACTITIONER'S EXPENSES CLAIM

Year ending April 4th, 195 .

* Household Expenses:

Rent (as net annual value)	...	.....
Rates	... ..	.....
Heating, Lighting, etc.	... ..	.....
Domestic Help	... ..	.....
Maintenance Repairs	... ..	.....
Laundry and Dry Cleaning	... ..	.....
Insurance (fire, burglary, etc.)	... ..	.....
Proportion allowed by Income Tax Authorities on account of practice	... ..	.....
* Expenses of Branch Surgeries	... ..	.....
* Telephone	... ..	.....
* Subsidiary Help (Gardeners, Window Cleaners, etc.)	... ..	.....
* Postage	... ..	.....
* Stationery	... ..	.....
* Flowers, periodicals for waiting-room, etc.	... ..	.....
* Replacement and repairs of surgical equipment	... ..	.....
* Subscriptions to professional associations	... ..	.....
* Books and current medical literature	... ..	.....
† Secretarial help/receptionists	... ..	.....
‡ Redecorations of surgery premises	... ..	.....
§ Car expenses (Mileage . . . .)	... ..	.....
|| Locums	... ..	.....
* Other travelling expenses	... ..	.....
* Accountancy fees	... ..	.....
* Sundry	... ..	.....

* The figures included under these headings should be those submitted to and accepted by the Income Tax Authorities.

† No claim will be allowed under this heading if the number of patients on your list was less than 500 at the end of the financial year. If your list was between 500 and 1,500 you may claim up to £150; if over 1,500 up to £300.

‡ Claims submitted under this head must be accompanied by an estimate which has been accepted by the Claims Committee.

§ The mileage undertaken for all practice purposes (N.H.S. and private) may be included here.

|| Claims under this heading may not exceed £120 (locums expenses for six weeks).

The following items of expense may be allowed for income tax purposes but are not subject to claim here:

Assistant's salary	Mortgage payments
Dispenser's salary	Bank loans
Nurses' salary	Bank charges
Drugs	

NOTES ON CLAIMS

Most items of expenditure would be repaid on the same basis as that used for income tax claims. These items are starred on the Claims Form. Some items, however, call for special treatment and these are dealt with separately below.

Secretarial Help and Receptionists

A doctor with 200 patients could hardly claim to need even a part-time secretary nor could one with 4,000 justify employing two whole-time secretaries. Some rule would thus have to be laid down and the M.P.U. tentatively suggests that doctors with lists of 500-1,500 could claim up to £150 p.a. for a part-time secretary and doctors with over 1,500 patients up to £300 p.a. In all cases it would be necessary actually to employ a secretary before a claim could be submitted.

Redecorations of Surgery Premises

The State could not be expected to panel the doctor's waiting-room in satin wood, but it should meet all reasonable costs of redecoration. This could either be done by a special allowance every few years or preferably by the submission and approval of an estimate when the doctor considers it necessary.

Car Expenses

It would be impossible to repay car expenses on the basis of income tax figures; some doctors run big expensive cars and others small economical ones. Some way must therefore be devised for repaying the car expenses on an average reasonable basis. The M.P.U. suggests that a Central Mileage Committee could determine each year a mileage rate which would take into account the following elements: cost of petrol, insurance and tax, tyres, and average amount for repairs and depreciation. The claim would then be paid on a mileage basis and should meet fully the motoring expenses of the average doctor. The doctor who bought a new 30 h.p. car would not have all his motoring expenses repaid (although he would continue to receive the usual benefit on his income tax claim); the doctor who ran an 8 h.p. car would gain financially. Thus there would be some inducement to practise reasonable economy. It might be necessary to establish a rather higher mileage rate for specially difficult country areas.

The present mileage payments include two elements, one on account of extra motoring expenses and the other to compensate for the increased time required to visit patients. The M.P.U. mileage claim would allow for the former but not for the latter. The mileage payments would still be made but on a reduced scale.

Locums

For the first time the Government would assume the obligation to provide holidays with pay for general practitioners. The M.P.U. has no hesitation in saying the proper holiday period is six weeks a year, as is already allowed for a consultant. A locum's fee (at say £20 per week) could therefore be claimed for this period.

Note:—Also included in the Medical Practitioners' Union's written evidence was a copy of an article entitled "The Future of General Practice" which was published in the "Medical World Newsletter" dated September, 1955.

Examination of Witnesses

DR. B. CARDEW, *General Secretary*DR. A. ELLIOTT, *Vice-President*

DR. H. C. FAULKNER

DR. P. HOPKINS, *Hon. Treasurer.*DR. H. WALDEN, *President*

on behalf of the Medical Practitioners' Union.

Called and Examined

550. *Chairman:* I would ask you, please, to understand that having had your evidence and read it with a great deal of interest we want to test what you say as to facts and expressions of opinion thoroughly because if we do not there is nobody else to do so. I hope I do not need to add that this does not imply either disbelief or any hostility, nor does failure to pursue any particular point that you make necessarily imply either that we accept it or that we consider it irrelevant.

Any member of the Commission will have a chance to ask you questions. We will try and deal with your evidence in a series of topics. We have for convenience given the task of sifting the many written submissions that we have received to two sub-committees headed by the two legal members of the Commission, and in this particular case our northern evidence sub-committee has taken the main responsibility. So Sir Hugh Watson will be doing most of the questioning, but within each topic, after he has given a start, other members will be asking you general questions.

Just as a beginning, Dr. Cardew, I would like to ask some questions about the status and membership, the representative character, and so forth, of your Medical Practitioners' Union. Could you give me an outline of the total membership, what it covers and what its particular characteristics are?—

Dr. Cardew: Yes. The Union was founded in 1914. It has been principally concerned during its lifetime with general practice rather than the other fields of medicine. Its membership is around the 5,000 mark. We have never tried to ascertain the exact membership and split it up into categories because when any doctor joins the Union we do not ask him precisely what work he is doing. I would guess that the general

practitioner membership is rather over 4,000 but I am not sure and I cannot put it more accurately than that. It is a national organisation and we operate in the British Isles and the North of Ireland. We have a local structure of area committees—there are seventeen area committees—so that the views presented today are not solely the views of the Council but were submitted to the seventeen area committees. All the points put forward were brought to the notice of those committees and were sent back again to the Council so it is not just a view of a few odd people centrally placed. Although we are a trade union we are a non-political trade union. We have no part in politics and we think that our membership is roughly representative of a cross-section of the general practitioner side of the medical profession. I think that, Sir, is all I can think of immediately that is relevant unless any of my colleagues wish to add anything.

551. And you issue various publications, do you not?—We publish the "Medical World" which is principally concerned with problems of general practice. It goes not only to our membership but to other readers outside, and we publish the "Medical World Newsletter" which goes to every practitioner and assistant in the country every month. That has been published now for seven years. In that way we try to put forward our views to the profession and to give the opportunity for all sorts of points of view to be expressed in that Newsletter.

552. Can any general practitioner who wishes join your Union?—Yes.

553. And there are no particular obstacles in the way of high entrance fees?—No. The only requirement is that they should be a registered medical

practitioner and pay the normal rate which is £3 3s. 0d. per year.

554. *Sir Hugh Watson*: In paragraph 2 of your evidence you tell the Commission that you propose to offer full evidence as soon as possible on the remuneration of all medical men and women employed in the National Health Service. We will be hearing from you further in due course on that matter?

—Yes, Sir. We propose to offer evidence on the hospital side, I hope in the next six weeks, and after that we shall try to unify it and come down to concrete instances in terms of money, which you will notice have been avoided in this document. There are no figures there.

555. You propose to offer concrete evidence on the hospital side. What about the general practitioner side?—First of all, we shall deal with the hospital side, again not in terms of recommendations of levels of remuneration, and then we shall have to put in a unified document finally which will make concrete proposals in regard to actual terms of money on both sides of the Service.

556. You have given us several interesting papers but the principal one is the one headed "Preliminary Evidence" and if it is agreeable to you I propose to go through that with you. Of course, we would be delighted if you would give any further supplementary views or facts you have to offer, and we would like to ask you some questions about it.

We were interested to see in paragraph 6 of this paper on this question of remuneration that you say:—

"The Union would deprecate any attempt to base the remuneration of general practitioners for the future on a comparison with a world now 18 years away."

Does that mean in effect, Dr. Cardew, that your view is that general practitioner remuneration now should not be based on the Spens recommendations plus an appropriate allowance?—It is all too easy, Sir, to adhere to a formula 18 years old and say that that is the appropriate answer. We rather felt that the fact that this Royal Commission had been set up with its terms of reference made it necessary to depart from that sole adherence to the Spens formula. Although it is

one of the strong arguments that has to be brought in, it cannot be the only one. We are living in a different world today and we have to think in new terms.

557. *Professor Jewkes*: How does your answer link up with paragraph 4 of the document where you suggest that if some of the comments made by the Spens Committee had been noted more closely by the government of the day many of the existing anomalies could have been avoided? In paragraph 4 you are rather suggesting that a closer adherence to Spens might have been desirable but paragraph 6 rather suggests we should start again and think the thing out de novo. Can you comment on that?—I do not think there is any inconsistency between the two. After all, the Spens Committee was set up at the end of the war to investigate the levels of remuneration and the spread of remuneration. As we subsequently analysed those recommendations we felt that if closer attention had been paid at the time to some of them immediately after that, if the government and the profession had done that, then a great many of the anomalies which we think have been introduced into the Service would not have been introduced. I do not think that is incompatible with saying many years later that we cannot now return right the way back to Spens and base the future of remuneration and distribution solely on the recommendations the Committee made in those days.

558. *Sir Hugh Watson*: You would agree that Sir Will Spens and his Committee were looking into an unknown future?—Yes, we make that point.

559. But you are prepared to let bygones be bygones and start afresh?—Yes.

560. In paragraph 7 you quote the well-known statement of Mr. Aneurin Bevan, and then at the top of Page 5 you say:—

"The Union believes that after nine years' experience of the Health Service it can be said categorically that there has been 'an unfair worsening of a doctor's material livelihood' . . ."

I take it that means in comparison with remuneration now current in other professions?—Yes, and in terms of our own profession in the past.

561. I can see that you probably have a good deal of information about your own profession in the past but if you are comparing your present remuneration with that of other professions have you in fact any information about these other professions? This was a basic Spens point.—Yes, it was a basic Spens point although I do not know how they made a judgment because I do not know of any actual statistics.

562. As you know, it is part of the work of the present Commission to consider how the levels of remuneration of doctors in the Health Service compare with levels of remuneration of members of other professions.—Yes.

563. And, as you know, a questionnaire is being sent out to all the other professions.—Yes.

564. And the answers that have been received from that will link up with your remark that you are starting afresh.—I think that is a very relevant fact and I hope those figures will be published.

565. They will indeed, yes. In the same paragraph you say that "a sense of real professional opportunity" is still missing from the Service. You are using Mr. Aneurin Bevan's expression?—Yes.

566. I do not know that this is necessarily concerned solely with remuneration. Could you perhaps tell the Commission exactly what you mean by that?—We read into Mr. Aneurin Bevan's words not only that the medical profession would be well looked after financially but that there would be new vistas, new opportunities of practising better medicine in the Service and we feel, due to the anomalies of distribution which we subsequently go into, that that statement has been largely negated by subsequent developments. I know that it is the strong impression of all my colleagues here, and of myself, that there is a general feeling in the profession—I am talking about the general practitioner side throughout today—that leaving remuneration aside there are so many features of the Service we do not like, so many anomalies in it, that they felt frustrated regardless of their particular earning level.

567. So that really the content of that sentence is not a matter for this Royal Commission?—I do not know how far you mean . . .

568. Our terms are concerned with remuneration, which is wide enough in all conscience!—Yes.—*Dr. Hopkins*: This phrase means to us really the opportunity of obtaining a high standard of practice and I do not feel we can divorce the standard of practice from the question of remuneration.

569. *Chairman*: I am not very clear about what is meant by those answers. I do not know whether you can give us an example of the kind of frustrations you have in mind, can you?—*Dr. Cardew*: I am just wondering whether we can develop this point as it is very relevant, but there are a number of stages in this document, particularly when we come to deal with expenses, when these arguments will be developed best—if we are given the opportunity—and where the question of the standard of medicine and the satisfaction of a doctor's life are seen to tie up closely with the question of remuneration. We do not want to sidestep this question and we would like the fullest opportunity of developing it but we think, if you would not mind, we would rather do it at that later stage.

570. *Sir Hugh Watson*: Could we have some clarification of the meaning that you were placing on these words: "... a sense of real professional opportunity" is still missing. . . .? Is that a criticism of the Service as a whole or just the frustration of the doctor himself?—*Dr. Faulkner*: I think that we will be able to give examples later on, under the appropriate headings, of the way in which initiative and the development of general practice have not only not been encouraged by the system of remuneration but have actually been hampered and even prevented. We ourselves, I think, can all give personal examples of this, and, certainly, we have knowledge of many other practitioners who have actually been unable to carry out developments in line with modern advances, developments of techniques which have actually been either prevented or severely curtailed by the present system of remuneration. I do not see how we can go further at the moment without giving you actual details which surely would come better when we are discussing the expenses and the precise points we want to raise.

571. *Mrs. Baxter*: May I ask at the same time when these answers are given to us, and perhaps you will bear this in

mind, whether the sense of frustration is due principally to questions of remuneration or to the fact of the immense expansion of the science or art of medicine that has taken place in recent years; and whether the frustration is due to the inability of doctors to move as fast as they would like in keeping up with all the new techniques? This seems to me to be very relevant.—*Dr. Cardew*: We would very much like to go into this question later, if we may.

572. *Chairman*: We will leave this general point now but if we find in the course of the day we have not covered it as we expect then we will come back to it at the end.—Yes, Sir.

573. *Professor Jewkes*: Before we leave paragraph 6 can I get clear in my mind the meaning of this phrase: "an unfair worsening of a doctor's material livelihood"? I suppose one of the things the Commission ought to try and do is compare the general movement of earnings per head in different professions, say, from 1938 to 1955. Do you know of any information that would enable us to make that comparison?—No, Sir. We have thought about this and realised the extreme difficulty there always is in getting any profession to divulge the movement of its earnings and we did not feel competent to do this. But we knew that the Commission was doing this work and actually sending out a questionnaire. We have no particular evidence to offer on this that we feel would be of value to this Commission.

574. You must understand the questionnaire that we are sending out will be confined to two very recent years, but my question was directed to the possibility of comparing the movement of earnings per head in different professions. Up to now we have no guidance on that at all, and I understand that you have no information either?—I am afraid not, Sir.

575. *Sir Hugh Watson*: Your paragraphs 8 to 24 deal with the Spens Report and its recommendations. You say generally that a very considerable number of the specific recommendations of the Spens Report have not in fact been implemented. I think we will leave it at that for the moment.—Yes.

576. However, can you tell the Commission this? Why in your view is that so, bearing in mind that the present

structure of remuneration is a matter of agreement between the Ministry and the B.M.A.? It has all been negotiated, you know, with the B.M.A. and it is a matter of agreement.—Yes, Sir. I think the answer is really quite clear. You will remember there was an agreement between the Ministry and the B.M.A. but it came at the end of a very long and acrimonious period of dispute. My own view is, although I was not associated with the negotiations at the time—we are now part of the official negotiating machinery but at that time we were not. . . .

577. . . . Your Union is now part of the negotiating machinery?—Yes. Both Dr. Faulkner and I have been for many years on the General Medical Services Committee of the B.M.A. which does all the negotiating on behalf of the general practitioners and the B.M.A. altered its constitution in fact so as to include two members from the Medical Practitioners' Union. So we have been closely associated with it in recent years but were not, of course, in 1948. I am quite sure that at the end of this period of negotiation and difficulty both the Government and the profession were only too anxious to arrive at a compromise which could be brought into operation very soon, and I think any difficulties on interpretation of individual recommendations were conveniently forgotten.

578. I see. Thank you. I am now looking at paragraph 11 in which you deal with the spread of incomes. I gather that this paragraph has really endeavoured to work out the distribution of general practitioner income according to the size of lists. You point out that in your view it would be indispensable for the Royal Commission to obtain accurate figures on the present spread of practice incomes. This the Royal Commission are going to do and we hope it will result from the questionnaire which has been sent out and which you have probably seen. You will agree that the Commission's questionnaire will probably give better information about that than is at present available to anybody, do you?—Yes, providing that the doctors co-operate.

579. *Professor Jewkes*: May I ask a question? I would like to understand what your attitude is on paragraph 11. Am I putting it right when I say that

as far as distribution of the central pool is concerned your evidence seems to suggest that that distribution at the moment differs from the one recommended by Spens?—Yes.

580. Your next step is to say that since it departs from Spens then it is wrong. Is this a case where you want to hold up Spens as the appropriate standard?—No, Sir. We feel that no investigation into remuneration at any stage is worth anything if it is conducted solely on a global basis. You might devise some system of remuneration by which half the people have £10,000 a year and the other half have £1,000. Clearly that would satisfy only half the profession. You must have some pattern of distribution if you are going to have a satisfied profession, and what we have tried to show is that no attempt has been made to obtain such a pattern. We want to go no further than that.

581. There is a pattern but it is a pattern which differs from Spens?—It is a pattern which is unknown and derived from a lot of haphazard factors.

582. Suppose I said that I thought the existing distribution was preferable to that recommended by Spens, what would be your answer?—I would ask you how you knew what the existing distribution was because no one else does!

583. I am assuming the distribution you suggest in these ingenious tables is the correct one. Sooner or later we will get the correct one, but suppose in fact we do finally discover that the existing distribution differs from Spens would it be your view that we ought to regard Spens as the standard? That is the point that I want to get at.—No, Sir. We do not regard the Spens distribution as sacrosanct in any way. But clearly there must be certain principles of distribution within a profession, and we would be prepared to give evidence on that if so required. What we do maintain is that any system of distribution should know what it is attempting to do and try to achieve the result it wants to achieve. What we are saying is that under the present system you have a system which does not enable you to do in fact what you want to do—that is all.

584. *Chairman*: Do you say that it is essential that when you have a system you should be able to know whether or not it is carried out?—Indeed, yes.

585. *Sir Hugh Watson*: We shall have occasion to come back to the table which is produced in paragraph 27, and a very useful table it is. In paragraph 34 you pretty well suggest that the Commission must to some extent enquire into methods of distribution if it is to do the job properly.—You are jumping all the other paragraphs, are you, Sir?

586. Unless you want to refer to them.—I want at some stage to develop the argument on which we set the greatest store in paragraph 28.

587. If you please then.—We feel very strongly on this subject that this system of calculating the central pool is such that no one item can be weighted in the public interest or in the doctors' interest without at the same time lessening the pay from other sources. We have had one very good example of this recently which I think is very relevant to this argument. You will know that the Ministry decided recently to have a great polio immunisation campaign throughout the country. General practitioners are going to be able to take part in this—and they want to—as well as the local authorities. It is estimated—I am not prepared to give figures, I am not sure whether the figures are material—that something like eight million of the population may be inoculated, that is, everyone under fifteen and expectant mothers. I am not sure how many items of service this is going to bring about from the general practitioners—how many extra items of service—but I would guess it would be somewhere in the neighbourhood of eight to ten million because there are two injections for each child. Each doctor will receive 5s., not for doing the injections because that is part of his contract, but for notifying the local authority. That money will be paid to the general practitioners but it will also be declared by the local authorities to the Government as a source of income paid by local authorities to general practitioners and will be immediately removed from the central pool. Therefore, this fantastic labour which is now going to be undertaken by the general practitioners of the country is going to be remunerated at exactly nothing. We think this is an extraordinary anomaly and I would like to ask two of my colleagues who have particular experience in this—they have started these inoculations—just to tell you briefly, if you will allow them, something of the work

entailed in these inoculations. May I pursue this just for a few minutes because it is considered to be relevant?

588. Yes.—*Dr. Elliott*: The position is that the parents of schoolchildren are handed forms at the school in which they are asked whether they wish their children to be immunised and whether they wish their own doctor to do the immunisation. In my area most of the general practitioners have agreed to do this work because they consider this is part of family doctoring. We then receive forms from the Medical Officer of Health giving the names of these people—blue forms for boys and red forms for girls. At a certain time and at certain intervals as the vaccine arrives we receive a bit of paper from our Medical Officer of Health to say: "Dear Doctor, we now have available so many ccs. of this vaccine for you to pick up". I then have to go along and pick this stuff up and it has to be kept at a certain temperature and is stored in a refrigerator. I then have to get my secretary to write to so many people who have got cards and ask the mothers to bring their children along, and then half the time some of them do not turn up. This is a terrific administrative job and if we are going to have these large numbers of people coming in, it is really going to be an awful job. In my practice I run special sessions for this, and when the lymph is available we try to do 20 at a time. But there are large and difficult problems connected with it because I have to go to the Public Health Department, collect the lymph, write to the parents, and I have got to keep the vaccine at a certain temperature in a refrigerator. Altogether, it is a very difficult job.—*Dr. Walden*: In my particular area the system is very similar but there is just one technical difference and that is that each individual boy or girl by name and address is told that that lymph is available for them for the inoculation. We have to go and collect it and we have to bring it back and put it in a refrigerator. The other technical point is that it is sometimes not available in individual ampoules, in nine or ten c.c. ampoules, and if you arrange to get ten children to come along and only eight arrive you are going to have to lose the other two c.c. injection; it must be discarded and you have to apply again for those two other people. On each occasion you have to go down to

the centre and this has created a problem—so much so that they have established other centres than those in the centre of the city. The other point is that of offering the public the British or the American vaccine and I can foresee very soon that we shall be told that so and so who wants British vaccine cannot have it and that they must have the Salk vaccine. We are going to have that trouble with the parents very soon.—*Dr. Cardew*: If I may return to this; we do not want to belabour this point but it is merely an example of the anomaly of the pool by which you can require the profession to undertake an enormous extra labour which they are willing to undertake, but for which they get precisely and exactly nothing.

589. *Mr. Gunlake*: Are you contending that remuneration should be entirely by item of service or is this a highly specialised matter which has arisen once and once only?—No. What we have tried to maintain in this document is that you must have enough flexibility in your remuneration so as to encourage doctors to do this sort of work in your own interest. There is no way of providing encouragement if you remunerate them at one end and take it off at the other.

590. *Chairman*: We are on the general heading of distribution, are we not, from your paragraph 27 onwards? Do I understand that while this in total gives a lot of extra work for which there is no extra remuneration, this work is paid for? The doctors who will carry out the work get paid something extra but doctors who may be in an area where there are virtually no children would, therefore, get less than if this work had not been done?—Yes.

591. It is related directly to the amount of work theoretically to be done, is it?—Yes. It is a very slight redistribution of the central pool which has that effect. I agree, but nothing is added to the total of the pool.

592. *Sir Hugh Watson*: In fact, the doctor who does the work will get the notification fee?—Yes, but let us take the average general practitioner who undertakes "X" inoculations and receives £100. He thinks that is extra remuneration but in fact he little knows—he does not realise—that the £100 is going to be deducted from his final settlement money.

593. *Chairman*: He ought today to know!—I am afraid many of them do not.

594. You gave this as an example. Is this the kind of thing you prefer? That is to say, that payment shall be related more closely to the work performed than purely a capitation fee as regards the person whether it involves work or not?—No, Sir. What we feel as a Union is that we want to retain the capitation method of payment and we want to get a proper rate of capitation for the job of doing all the normal requirements of general practice. But outside of that we want to treat all the other items as a separate problem of remuneration to be settled by separate negotiations.

595. Can that easily be defined—what is outside?—I think so.

596. *Professor Jewkes*: It is, of course, defined for the purpose of calculating the central pool.—Yes. There is another example we can give. If the Cranbrook Committee in its wisdom, decide to announce that general practitioners shall be paid 15 guineas for each confinement instead of 7 guineas, which they now are, there may be some rejoicing amongst some practitioners. But their colleagues will not rejoice when they find out that the extra money will be taken off the other end of the scale for capitation, which will be the result.

597. Can we be certain how this works? Can we go back to the polio case? If enhanced payments are made to doctors by local authorities this will mean that the capitation payments of all general practitioners will be reduced?—Yes, Sir.

598. They will all in that sense suffer. Those who get large payments from the local authorities for the performance of these polio inoculations may in fact receive more on that than they lose on the other?—It is possible yes.

599. So that those people who are heavily engaged in polio vaccination will perhaps gain something?—It is quite possible, yes.

600. *Chairman*: Is it not in fact certain?—No, Sir, it is not certain because it has got to be considered as proportional to the size of the list. In other words, a man with 3,000 patients on his list would have to do three times as much as one with 1,000 in order for him to gain at least three times as much.

601. *Professor Jewkes*: If I may carry on with that point; the doctor who would have a grievance would be the doctor who was not doing polio vaccinations, since his capitation fee is being reduced although the work he is doing remains unchanged?—*Dr. Faulkner*: There are general practitioners who say they have a very high proportion of old people on their lists, and a correspondingly low proportion of children in certain parts of the country—seaside towns, and so on—and it might well be that these general practitioners have very little opportunity of doing these injections. Or the local authority may prefer to make other arrangements—I believe this is permissive for the local authorities. It is an example of a very untidy method and a method which is not understood by most general practitioners, and which can operate very unfairly. This happens to be the most typical example though not necessarily the very best example. But we hope that this will illustrate the point that this is a very anomalous method of paying doctors who certainly do not feel they are being paid fairly and adequately for the work they actually undertake.

602. *Chairman*: As things are at present, Dr. Cardew, there is not very much variation from one area to another in the amount of the total of the central pool that comes by way of the capitation fee? It would not vary by more than say 2 or 3 per cent., would it, as a result of these things?—*Dr. Cardew*: I have not worked it out but I should not think it would vary much, no.—*Dr. Hopkins*: May I stress one point which may not have been clear to you. It is not just a question of Dr. A. getting more remuneration because he does inoculations for polio than Dr. B. who does not do inoculations, but Dr. B. in fact would be getting less remuneration for doing the same work as he is doing all the time.

603. I think that point is understood. There is the central pool and if one gets more another gets less?—*Dr. Faulkner*: Could I raise one more point on the question you have just raised? I think the reasons why the variations are so small is that many doctors who are giving some of these services outside pure general practice really do not feel it is worth making a fuss about it. For

example, I receive £30 a year remuneration for attending eighty old ladies twice a week. Well, this scarcely pays for the petrol I use but I and other visiting medical officers feel it is scarcely worth while going through lengthy negotiations in order to get a fair rate of remuneration for that particular work, if this simply means an adjustment in the central pool. I would think that this has held back many people from pressing this type of claim.—*Dr. Hopkins*: That applies to other items of service that come out of the central pool, such as when one is asked to give an anaesthetic for a colleague. There is a fee laid down but it is not worth claiming because this merely again reduces the capitation fee.

604. This figure you mentioned, Dr. Faulkner, of £30 for these visits to the old people's homes, is that paid from the pool?—*Dr. Faulkner*: It is paid by the local authority but in the same way as has been described it is deducted globally. It is part of the remuneration paid out but I am in fact paid by the local authority that is for services other than the pure services covered by the capitation rate.—*Dr. Elliott*: I should like to mention this question of the maternity services. I know this is under consideration at the moment but every year at the meeting of the B.M.A. there is a resolution asking that the rate for looking after a woman for her midwifery should be increased. The 7 guineas, which was not very generous in 1948 for the doctor who conscientiously sees his patient all the time and who may be called out in the middle of the night to do a difficult confinement is absolutely ridiculous today. But on each occasion when the Secretary, or the Deputy Secretary of the B.M.A., record a motion to increase the fee it is voted down, in response to the 400 delegates who say that if you increase this money the rest who do not do midwifery will get less. I just make that point.

605. *Professor Jewkes*: It is because of this that you are suggesting that there should be a divorce between the arrangements for determining the capitation fee and the arrangements for determining other payments?—*Dr. Cardew*: Yes. Apart from anything else, one of the things that the Union is keenest about is getting a welding between general practice and the

hospital service and you can only move in this sort of direction if you can offer some sort of financial reward for people to come back into the hospital service again. You cannot do it under this system. We want to have it divorced so that any desirable feature that could be added to general practice can be done without this anomaly.

606. *Chairman*: To come back to what Mr. Gunlake asked some time ago, you really want payment for items of service?—Yes. We have nothing against payment for items of service and as you know we already have it for midwifery. But we would not be in favour of returning to that for the basis of the whole of medicine.

607. *Mr. Gunlake*: What you are suggesting is first of all this divorce between the bread and butter work of general practice which would be remunerated by capitation and then other fields of special service which would be remunerated on a service basis. The point I would like to put is that two decisions would have to be made, first, as to what constituted the special field and, secondly, the basis on which it should be remunerated. How would those arrangements be negotiated?—I do not think you can draw the antithesis. You cannot say that we are asking for everything else to be remunerated by items of service. In the hospital field it would not be by items of service but by a salary.

608. *Chairman*: We are really talking about general practitioners because the hospital field is not within the central pool?—I am talking about the general practitioner working in a hospital in answer to Mr. Gunlake, who suggested that was an item of service basis. What I say is if a doctor takes a job in a hospital—Dr. Hopkins has three hospital jobs and he is paid on a salary basis for that, not on an item of service basis but on a sessional basis—his remuneration would have to be settled by negotiation between the hospital authorities and the medical organisation.

609. *Mr. Gunlake*: That was the point I was trying to envisage. What administrative complications might arise in negotiating, for example, Dr. Faulkner's £30 a year?—It is negotiated now, but the point is that it is not negotiated with any great heart behind it because it is known that for every little success one

wins in regard to a sessional payment, there is a deduction from the pool.

610. Are you reasonably satisfied with the field of services which are at the moment recognised as being outside the capitation field, these local authority appointments, and so on, or do you think that field would become enlarged in the course of time?

611. *Chairman*: The type of service, not the level of fees?—*Dr. Faulkner*: I think the answer is, briefly, yes, providing there is a form of remuneration which does not hamper general practitioners taking on other work for which they are properly qualified, which they have time to do and which they wish to do. We would like to see for general practitioners a method of payment which gives them adequate time, adequate facilities to do their proper work—which I think has been fairly clearly defined over the years in general practice—and allows them to take on outside work for which they have time, energy, training and competence; a method under which they can negotiate quite independently and obtain a proper rate of remuneration and whereby they can feel they are not fighting for their own remuneration at the expense of their colleagues; a method that is not some very complex form of payment which only one in five thousand general practitioners really understands. That is what we have in mind.

612. *Sir Hugh Watson*: You say the normal sphere of operation for general practitioners is clearly defined. Do you mean under the Act?—I had in mind firstly the Act. I think most general practitioners know what their duties are under the Act, and while there are many interests, different lines of country—for example, Dr. Hopkins is particularly interested in psychotherapy and Dr. Walden does a great deal of obstetrics—I think most general practitioners are in fair agreement with what general medical services mean. But there are other jobs like local authority work, industrial and occupational health appointments.

613. And the local authority work includes poliomyelitis immunisation?—Yes, preventive medicine which at present does not come under the normal work of the general practitioner. There are other things, Treasury Medical Officer examinations, for instance, on behalf of the Government or local authorities;

work of that kind which it would be entirely up to the doctor to decide whether he took on. His remuneration would be a matter of determination between himself and the employing authority, whoever it might be.

614. Outside the pool altogether?—Yes, outside the pool altogether.

615. *Mr. Watson*: And outside the Health Service altogether?—In the case of occupational health it might be, but most of these things are inside the Health Service. But the type of thing we have in mind is perhaps a private employer who might well, and does employ a doctor. That doctor's remuneration also, would not be deducted from the pool, although at the moment it is deducted under the heading of private practice.

616. As a Union do you accept these two principles that firstly the doctor within the Health Service should aim at a proper rate of remuneration for working within the Service and that the rate of remuneration should be at such a level as would give him all the necessary material standards, and then secondly, outside the Health Service have the individual opportunity and right to enter into private contracts with private employers or other organisations? Do the Union accept that?—*Dr. Cardew*: Yes, we do.

617. *Chairman*: Dr. Faulkner, I may have misunderstood you but did you say that if you take on extra work for a private employer that remuneration is deducted from the capitation fee?—*Dr. Faulkner*: Not by items, Sir. There is a sum agreed between the profession and the Ministry to be from private practice and all payments of this kind, including payments from employers, would come under that heading.

618. *Sir Hugh Watson*: What is that sum?—£2 million.

619. When was that sum fixed?—*Dr. Cardew*: I do not think we ought to pursue this subject. We have no knowledge as to private practice. Dr. Faulkner, when he says that an extra fee obtained from private practice would immediately be added on to the £2 million . . .—*Dr. Faulkner*: I did not say that. I said it was included in the £2 million. I would not like to pursue this matter, if you do not mind.

620. *Professor Jewkes*: I am still worried about this separation of the systems of negotiation. Your first big suggestion is that there should be one system of negotiation for capitation fees and then negotiations should be carried out for the other items?—

Dr. Cardew: Yes.

621. Quite apart from the details, is this a good principle? May it not be that under the arrangements you are suggesting there would have to be more negotiations, separate negotiations for each of these things, which might mean there were more points of possible friction and disagreement for the profession?—I do not think so. I think the present system of negotiations, if you can call them negotiations—there have not been any negotiations at all, we claim there has been an edict from the Government—but in fact they really would be simple negotiations because they would be merely concerned with, to take a simple example, a job like attending a clinic in the afternoon. I should not think there would be any great complexity or difficulty about that.—*Dr. Elliott*: At the moment the Ministry of Health lay down rates for what they call general practitioner out-patients sessions and this is agreed with the profession. Also, the British Medical Association lay down rates which they think Industrial Medical Officers ought to be paid, and they refuse to accept advertisements by employers who do not pay those rates. Therefore, in effect there are, at the moment, rates which the profession ought to get and all we are saying is that these negotiations should be divorced from the central pool. For example, at the moment, the Treasury Medical Officers are mainly general practitioners. Their rates are laid down; there is negotiating machinery on behalf of these doctors and their rates are agreed. All we are saying is we would have them agreed but they would not have anything to do with the central pool at all.

622. *Sir Hugh Watson*: In other words, you do not think there is any difficulty about the alimony hut you want to get the divorce first!—*Dr. Faulkner*: Surely, this is the normal and rational way of looking at it. *Sir Hugh Watson* has re-stated what I said rather more clearly. Surely, he would be very surprised if one of his members was told

that the money that he earned playing in a dance band in the evenings would be deducted from the total remuneration of workers in the country. Surely, this is not the normal way in which people are remunerated for their spare-time occupation? They make their own arrangements privately without reference to a central pool.

623. *Chairman*: Do I understand that every general practitioner is in theory employed wholetime in the National Health Service?—In theory, but he is also permitted to carry out this other work when he has presumably properly carried out his duties in the National Health Service. That is not the point at issue. It is the method of remuneration.—*Dr. Hopkins*: Could I enlarge on that to say that in fact the doctor may not be wholetime employed by the National Health Service but he is in fact continually responsible for his patients throughout the whole day, 24 hours a day 7 days a week.

624. Whether they are National Health Service or private?—Yes, but the point I was going to make was that the fact that he is responsible for his patients throughout the whole 24 hours of the day does not necessarily mean he is seeing them throughout the whole of that time. He would have time to do these other jobs such as attending hospital clinics, and so on, without depriving his patients of any attention they might require.

625. *Mr. Watson*: Assuming that (a) you were able to negotiate what was considered to be fair rates of remuneration with all the necessary safeguards and (b) the general practitioner was allowed to work outside the service and make his own contracts, would the Union agree to the abolition of the central pool?—*Dr. Cardew*: No, Sir, I do not think we would because you would have to find some way of tying the size of the total task to the rate for the job, and the size of the total task would depend on the number of doctors and patients. Somewhere there must be brought into the formula a pool of some sort. All we are saying is that we think the pool ought to be for a more limited purpose and that there ought to be an area for negotiation outside that limit.

626. *Mrs. Baxter*: Do you think that the negotiations ought to be more or less continuous? When you are trying to

establish a norm for what is inside the general rates, that is to say, that would be covered by the capitation fee, one would expect the items would be constantly changing with the developments in preventive medicine, is that not so? For instance, you have been telling us about the polio cases.—In fact, the negotiations are continuous. The British Medical Association are constantly in contact with the Ministry over the area of service, the duties of doctors and the payments of fees. This process never stops, it is going on year in and year out but it is never published in the papers.

627. And this seems fairly satisfactory?—I think it is admirable. I think it works very well. The only thing we object to is that it is no good pursuing negotiations for additional fees because they are cut at the other end.

628. *Sir Hugh Watson*: The negotiations you are in fact speaking of do affect the pool?—Yes, all of them.

629. *Professor Jewkes*: Mr. Watson, raised this point and you said you would need a pool. I do not understand why you would need a pool if you introduced your system. Why could you not say that the capitation fee would be "X" shillings? Why do you need to keep the pool once you have divorced the determination of these different items?—Do you mean you could fix a net reward for looking after any patient?

630. No, keeping the capitation system. I am thinking of the capitation side now and what I was wondering was—I have just said the capitation fee would be "X" shillings—why do you need to keep the pool under your arrangements? What is the purpose served by it?—*Dr. Walden*: Expenses come out of that pool and have to be adjusted at the end of the year.—*Dr. Cardew*: I would like to think about it and come back to this after lunch.

631. *Chairman*: Could you tell me, Dr. Cardew, disregarding interim adjustments since the Danckwerts award was implemented, how much is the capitation fee per person, including the final adjustment?—I have not worked it out. It would be quite possible to do it. The final settlement is quite a sizeable sum now, I think. I think it is running at £4.2 million a year.

632. I am asking the amount of the fee per person—21 shillings, or whatever it may be—which is allowed for expenses. I would be interested to know if it has varied by more than a few coppers.—I do not know. I would have to work that out.

633. *Sir Hugh Watson*: Is it not a fact that it went from 17s. to 17s. 6d. last year?—*Chairman*: I mean including the final settlement.—It is divided amongst the profession as a final settlement in the capitation form.—*Dr. Faulkner*: The first payment made to the doctors is simply a payment on account.

634. *Sir Hugh Watson*: The 17s. 6d.?—Yes. They know the final settlement will be added to give them their final capitation fee but I do not think many doctors know what it is.—*Dr. Hopkins*: That final settlement depends essentially on how much has been deducted from the pool for all these payments we have been talking about.

635. *Chairman*: That is what I would like to find out, whether there has been so much uniformity in the total amount deducted for these other things that really it has not made much difference.—It varies very little I should think.

636. *Professor Jewkes*: You have not pressed for increases in payments for maternity services because it would not be to your advantage—you expect this sort of rigidity, do you?—*Dr. Cardew*: Yes.

637. Could I take the point Dr. Walden made earlier? As I understand it, you do not need the central pool because of the expense item, because the central pool is really a pool of net payments; the only purpose for which you need the pool is that you must have something from which you deduct payments for maternity services and the like?—*Dr. Walden*: It is not the entire answer. Previous to the fixing of the 17s., the capitation fee varied from city to city. It was not the same in two cities. It varied from place to place. We tried to remove that anomaly by this method of final calculation of the central pool. You would still have to have some form of pool when you have claims for more than 100 per cent. of the population in an area. I cannot think of anything more at the

moment. There would still have to be a central pool of a type but I cannot just think of any examples at the moment.

638. I am always learning something new about the central pool!—*Dr. Cardew*: The Government might assume an obligation to pay £1 for every patient in England regardless of inflation and everything else—but I imagine the Treasury would not be keen on that because if there was an element of inflation it would in fact work out at more than £1.

639. *Mr. Watson*: Is it a fair assumption that one of your main complaints against the pool is, taking not the theoretical average doctor but the doctor as a human person, that those who have the greatest get the greatest out of it, and those that have the least get the least out of it?—I am not sure whether this particular system of payment does influence that.

640. Let us take the doctor with £3,000 a year from all sources and a doctor with £2,000 a year from all sources. Who would get the most from the central pool?—Under the present system, of course, any upward variation would help the largest list man.

641. It would help the man with £3,000?—*Dr. Walden*: If distributed on a pure capitation and loading rate, yes.

642. *Chairman*: The loading is an extra complication I think we can take in our stride. You mentioned inflation just now, *Dr. Cardew*, I take it you mean inflation of lists and nothing to do with the monetary effect?—*Dr. Cardew*: I mean inflation of lists—the difficulty of maintaining up-to-date records.

643. *Sir Hugh Watson*: Am I right in thinking that the 17s. capitation fee was in fact fixed by the Working Party following the Danckwerts award?—*Dr. Walden*: I think it was.—*Dr. Cardew*: It is a convenient starting point. It is not a final figure because you must wait to hear what the final settlement is before you know what the final rate will be.—*Dr. Walden*: It sometimes takes two years before the final settlement is paid out.—*Dr. Cardew*: It was not fixed by the Working Party. All that the Working Party decided was that it would be safe under the Danckwerts

formula to pay out 17s. and 10s. loading as a start because then they would never be likely to be short of money to meet their final obligations under the Danckwerts formula.

644. For the payment of a basic capitation fee of 17s.—Yes, knowing it would certainly be higher when the final settlement was made.

645. *Chairman*: The capitation fee is not that which is a first instalment but is the total amount which may, as you say, take two years to calculate.—Yes.

646. I suppose you feel that so long as such a system exists only enough should be held back for the final settlement to make sure there is enough to spare, but that you should have the maximum amount paid out as you went along?—Yes. We have for a long time been pressing this point. We feel that now it is £4 million a year it is a very large sum to withhold for a long period such as two years.

Sir Hugh, I think there was a point that you were going to take up with *Dr. Cardew*?

Sir Hugh Watson: Yes, there was one item in paragraph 27 which does not affect the pool at all, the last item of your list, private practice, which is put in at £95. It occurred to me that this average doctor might happily be called "Dr. Watson." He is down for £95?

647. *Chairman*: That £95 itself I think, is part of £2 million?—Yes.

648. *Sir Hugh Watson*: That is "Dr. Watson's" share of £2 million?—Yes.

649. That figure of £2 million was the figure taken into account by Mr. Justice Danckwerts when he made his adjudication in 1952 and it has not been changed since. Has your Union, *Dr. Cardew*, any information about whether, in fact, the earnings of doctors in private practice have increased since 1952, or not?—I can honestly say, Sir—I have talked to many doctors about this—it is quite impossible to answer that and I mean that in every true sense of the word. It is quite impossible to ascertain precisely the amount of private practice in the country or its distribution, short of making an enquiry from every single doctor in the country. I have asked hundreds of doctors and the general impression is that there is a small

minority of doctors who still have quite a sizeable private practice, in certain small areas of London, certain residential parts of provincial cities, certain small areas and seaside towns. But the average doctor one knows in industrial towns claims, and they all claimed to me over and over again, that private practice is completely nil.

650. I take that from you, of course. I am sure that is so. But if a doctor has an appreciable private practice—and private practice has many facets, has it not . . .?—Yes.

651. . . . he is at liberty to meet inflation of money by increasing his fees according to the capacity of his patients to pay?—Yes.

652. And it is possible, is it not, that the £2 million could in fact have been increased very considerably?—It is possible, Sir. My own view is that the people who do private practice have almost certainly put their fees up and to that extent are receiving more money. But the total area of private practice is certainly diminishing because all the time as old people die their children do not go on to the private list, they go on the National Health list, so the area is diminishing. But the amount is probably increasing. Whether it balances exactly I cannot say.

653. You have, of course, an increasing number of the population now who are taking advantage of the various provident schemes that are available?—*Dr. Hopkins*: These are only for hospital fees, not for general practitioner fees.—*Dr. Cardew*: I am talking only about general practice.

654. I beg your pardon. I know myself, for instance that the fees paid by Insurance Companies to doctors for conducting medical examinations have, in fact, been doubled since the time about which we were talking.—*Dr. Hopkins*: Not doubled.—*Dr. Cardew*: 1½ guineas to 2 guineas.—*Dr. Walden*: The 10s. fee has been increased to 15s.; 15s. to 1 guinea; 1½ guineas had been increased to 2 guineas.

655. But going back to the Spens time it was a guinea or less?—*Dr. Hopkins*: No, it was 1½ guineas.

656. The point is there are various ways in which doctors can earn fees of that sort which are outwith the N.H.S. altogether?—*Dr. Walden*: A very

small amount, Sir.—*Dr. Hopkins*: Since those fees have gone up insurance companies have asked for far fewer examinations.

657. I am not talking about insurance examinations only. There are various ways in which doctors can earn fees in private practice outside the N.H.S. and it is possible the £2 million has increased.—*Dr. Cardew*: It is certainly possible, Sir, but I would like to make just one point that even if it could be shown that it had increased, it would be very difficult to generalise, in terms of all general practitioners. You may get whole areas, whole towns where the doctors get no benefit whatever from that increase.

658. I am quite sure of that, but to take you up on that previous point, the fact that their colleagues in residential parts of London earn more from private practice does not diminish the central pool?—Only if there were a new agreed total.

659. Precisely. But that figure has been left untouched since 1952?—Yes.

660. That is the point.—Yes, I hope, Sir, that one of the conclusions of this Commission will be to take this private practice figure outside the pool whatever else happens, because it is a perpetual source of difficulty. As far as I can see there is no answer to it unless you have a detailed elaborate investigation every year with every doctor's earnings listed and there would never be agreement on it.—*Dr. Hopkins*: In any case it does not matter how much any one doctor earns from private practice. It still should be a principle that a doctor should receive a certain rate of pay for the job of looking after a number of National Health patients. It does not matter how much private practice he has, he should still get the right rate of pay for looking after a number of National Health patients.

661. That is the point you make in paragraph 41, and I will take paragraph 41 now. If we take "Dr. Watson" again, with 2,200 patients, you say he gets £2,370 from the pool. You then compare him with a radio mechanic or a plumber which is hardly appropriate, is it, *Dr. Cardew*?—*Dr. Cardew*: Only appropriate in that his rate of pay for individual items does not seem to be very remarkable. We thought it might strike home as an argument.

662. I do not know. In this paragraph first of all you propose that general practitioners' remuneration should take no account of what their earnings are outside the Service. That is your first point. Of course, you have already agreed that you want to get away from Spens but that was a basic conception of Spens that the whole of the doctors' remuneration should be looked at, was it not? You say you want to get away from Spens in this matter?—We do, quite definitely, Sir.

663. If that is what you want then we do not need to bother about plumbers and mechanics. Really the point is that of the remuneration of doctors who do nothing beyond the N.H.S. job. You know he receives £2,370, it is on your table in paragraph 27, and then you deal with expenses which on a national average are 33.4 per cent. You say his expenses are probably higher than the difference between £2,370 and £1,580; you say they are probably £1,000?—Yes, if he were doing nothing except this, and had no other source of income.

664. If he had no other source of income it is quite open to him to increase his panel, is it not?—*Dr. Walden*: It is extremely difficult. Practices have not varied a great deal in the past five or seven years. Taking all in all they vary very little.

665. They are settling down?—*Dr. Hopkins*: Even if that were not true, I would maintain that it would not be in the public's interest for doctors to try to increase their panel above the average of 2,200. I would consider that a reasonable number for any doctor to be expected to look after adequately throughout the year.

666. In paragraph 45 you suggest a reduction from 3,500 to 3,000.—*Dr. Walden*: Yes, Sir.

667. You now want to reduce it from 3,000?—Ultimately. I feel very strongly that the number should be reduced to 3,000—a hundred per year. That is the first move.

668. I am suggesting to you that a doctor can increase his panel, if you like to call it that, above 2,200. Doctor Hopkins says that he considers 2,200 the largest number a doctor can look after. In your own paragraph 45 you want to bring it down to 3,000.—*Dr. Cardew*: There is no discrepancy here. There are

two points. One is that even if you agreed in theory that the maximum for the country ought to be brought down to 2,500 it would be impossible to do so because there are areas of the country where the average number of patients on a list is somewhere in the neighbourhood of 2,800. Therefore it would be impossible even if one thought it desirable. The other point is this, that the capacity of doctors to undertake work varies and also the speed at which they work. I am quite sure that Dr. Hopkins, whose practice I know very well, and with the particular type of approach he has to people and the amount of psychotherapy he gives, is quite right to say he could not look after more than 2,000 patients. But I am quite sure there are other doctors who feel quite clearly that they can look after more than 2,500, perhaps as many as 3,000. Dr. Walden's average, I believe, is in that amount.—*Dr. Walden*: Mine is 3,000.

669. This is not a thing you can be dogmatic about?—*Dr. Cardew*: You cannot be dogmatic but obviously one has to put some sort of limits on the amount of earning power otherwise it is grossly against the public interest. You will get some doctors who will take on many more patients than they can cater for.

670. *Professor Jewkes*: Would you expect a reduction from 2,500 to 2,000 would involve a need for more general practitioners in Great Britain?—*Dr. Walden*: Yes, Sir.—*Dr. Cardew*: Not necessarily.—*Dr. Walden*: I think more general practitioners would be required.

671. The point I am making is that some lists would inevitably be smaller than the average. Therefore some lists must inevitably be larger than the average, and there will come a point, as you admit, with the reduced maximum size of lists where you will have to say this will call for more doctors. You are prepared to face that consequence of a reduction, are you?—*Dr. Cardew*: Yes, Sir. I do not know whether anyone knows whether the previous reduction from 4,000 to 3,500 actually brought about an increase in the number of doctors in the Service. We know there has been an increase but whether it has been due to the reduction in lists is very unlikely. In any case it would not have come to pass yet because not seven years have passed since the Danckwerts award.

I think that redistribution has taken place within the profession quite straightforwardly, without the actual necessity of introducing many new doctors.

672. I was just wondering whether in view of the fact that you do not quite know what the consequences of reducing the maximum size of list would be, whether you think a reduction in two or three stages and not with such a large drop as this might have something to commend it?—We did recommend a reduction over three years by stages. We are very concerned with this problem.

673. *Chairman*: Do you consider that a partnership of three or four people can do a little bit more than that number of times the patients that a single-handed person can take on?—*Dr. Walden*: I can answer that from a practical point of view. I am in a firm of five doctors—four doctors and an assistant—and there is no doubt whatsoever that the only way we can deal with this large number of people is because we are, if I may put it myself, an efficient working organisation, a firm of doctors. I still feel that in spite of that, the numbers should be reduced approximately 100 a year to this 3,000 level.

674. But the point is that you say a partnership can deal with rather more?—*Dr. Faulkner*: I would qualify that, Sir. There is a tendency in a partnership to take on wider responsibility. You tend to follow up the interests of one or other partners, you tend to do more psychotherapy, perhaps some minor surgery and, in fact, many partnerships find they spend just as much time on the same number of patients as they did before. But they spend it more efficiently and probably save the hospital service a good deal of hospital work. I think one has to qualify that and I would not therefore say that if it was possible to change the structure to four-man partnerships throughout it would necessarily greatly affect our opinion that lists should be lower. I think we would more like to see more time spent on the patients. The organisation of partnerships should lead to more being done for the patient in general practice. We would like to see all that can be done for a patient being done rather than more patients getting the same level of care.

675. *Mrs. Baxter*: This would be in the patient's interest really rather more

than in the doctor's interest?—*Dr. Walden*: I think so.—*Dr. Cardew*: The two cannot be separated, Madam. I mean this very seriously indeed. We feel that you cannot separate a doctor's financial interests from the interests of the Service and the patient. The doctor has to get a certain satisfaction out of his life and it is only in succeeding in helping his patients through good organisation and good medicine that he himself gets satisfaction. So the two are intimately bound up.

676. *Sir David Hughes Parry*: I take it you have studied the Willink Report. They contemplate, as you know, an increase in the number of doctors by about 600 over a period of 15 years?—We feel their claims were unjustified and that the same type of reasoning as they put forward could, with equal logic have been used 20 years ago to hold the number of doctors at the then much lower level; they did not then anticipate all the intangible bettering of standards and expansion of the area of medicine which is inevitable in any society. We just think they were wrong.

677. *Professor Jewkes*: This is most important. I wonder if we could invite the Medical Practitioners' Union to give us a reasoned statement on the Willink Report.—In writing, Sir?

Chairman: Yes, thank you.

678. *Mr. Gunlake*: If you anticipate a reduction in the size of the list to something of the order of 2,000 or a little more, would that in your view impair to any extent the freedom of choice of doctor by patient or would it, to any extent, limit the degree to which you can reward the personal ability of a general practitioner?—I think both those points are to some extent true, Sir. Every time you reduce the maximum size of list you are to some extent interfering with the freedom of choice of a patient. But one has to recognise the fact that every patient's choice is to some extent interfered with and has been always. Where I practised medicine in the country, West Somerset, there were only two doctors within ten miles. Patients had to like me or like my competitor; there was no one else to like or on whose list they could go. That would certainly apply to some extent every time you reduced the list. But there is another stage we are recommending and this is a tendency we have noted for doctors to

get together in groups, in co-operative practice. Here the question of choice for the patient is not quite so important because when you have a group of four doctors working in premises together, while you may be on the list of one who you do not like very much, you may be able to see any of the other ones. In a sense it is not quite so difficult a choice for the patient to have to make. On the other side, there is that difficulty that Mr. Gunlake raised—the question of maintaining the highest rewards, the Spens 9 per cent. at the top of the earning scale. If you are going to reduce that the only way I can see you can do it is to allow doctors to take on a lot of commitments outside the Health Service. Certain doctors could do so.

679. *Chairman*: But that is not the object of reducing the list?—That is not the object, I agree, but some doctors would be able to maintain higher rates by taking on, if they had enough energy, other fields of activity.

680. *Mr. Watson*: What is the main object of reducing the list from X to X minus?—*Dr. Hopkins*: I would say the object is to allow the doctor to have a reasonable number of patients on his list, which means he would be able to do more personally for them rather than having to send a large number to hospital.—*Dr. Cardew*: And have a more satisfactory life.

681. Just as a point, does that not conflict with the aim of the Union for freedom outside the National Health Service to take on private patients?—You still have that freedom.

682. It seems to me that the first thing, to reduce the list, however meritorious it may be, conflicts with the second object of the Union to have freedom outside the Health Service to take on private work.—*Dr. Faulkner*: We want adequate remuneration for reduced lists.

683. I am raising the question of the care of the patient. If the argument is that you care better for the patient under the Health Service by reducing the list, then it would ipso facto follow that if the doctor would then enter into work outside the Health Service, the argument falls to the ground.—*Dr. Hopkins*: It does not necessarily follow because I could see the possibility of a doctor having a full list referring all those requiring anything in the way of

treatment to hospitals; he would still have time to do other outside work if he so wished. The number of patients you have must limit the amount you can do for each of them.

684. *Chairman*: I think you have rather indicated already that there are doctors who would be sure to exploit any such opportunities just as there are many who would not?—(*Dr. Cardew*): I think one has to be very realistic about this. In the medical profession you have all sorts and kinds of practitioners. They are not a uniform bunch of people, all doing their work in exactly the same way. You have different levels of energy, different levels of interest. I know doctors who, quite frankly and quite honestly, could not have more than 1,500 patients with their method and speed of work. It takes them all their time to look after 1,500. I know others who claim to look after 3,500 and take on jobs outside. I do not know whom to believe on these things but I am quite sure the capacities of human nature are very variable and I think one has to make some allowance for that. You do not want to reduce the job of the National Health Service doctor to completely a dead uniform pattern. There are some practices where individuals want to do more of a certain sort of work than others. *Dr. Hopkins* is keen on psychotherapy; *Dr. Faulkner* has a whole group of facets developing; there is the social side and other sides in other practices where you have a different pattern. You do not want to lay down a rigidity. But I think you must leave an opportunity for those doctors who do want to do work outside, leaving aside pay altogether.

685. *Mr. Watson*: Assuming they have the time and capacity?—Yes.

686. *Mrs. Baxter*: Would I be right in thinking that the doctors' difficulty is at least in part due to the fact of the increasing health education of their patients; that the patients now probably tend to take up more of the doctors' time because they wish to know rather more about their own case than they were ever inclined to know in the earlier years? The patient is likely to want to take up increasingly more of the doctors' time as he or she learns more about their human body.—I am the only one of the doctors here who is not in general practice. I will leave my colleagues to

answer that question.—*Dr. Faulkner*: I think that is partly true. But it is a vast subject and I do not know if you want to go into that now. It really amounts to the whole influence of many years of health education which goes from television to the women's magazines in this country. This is the sort of thing that is good for a three-hour discussion after dinner. There is not a short answer to it.

687. It does affect the question of whether the members of the Commission are thinking in terms of the steadily increasing amount of time a doctor spends on his patient.—I think that is partly true, but on the other hand my own impression, which may not be shared by my colleagues at this table, is that many of our patients are very much more intelligent about minor illness and only come to see us frequently because of the demands of certification. For example, they know that we cannot effectively treat the common cold and they will treat themselves and then come and ask us for a certificate after they have been off two days and that kind of thing. I would say that the general attitude of the working class mother towards her child today is so different from when I was a student 20 years ago that there are less demands in some respects and more in others. It is very complex. I think Mrs. Baxter is correct in saying that the total effect is that the patient demands more from his doctor. I think there is a greater need for psychotherapy, probably because of the pace of modern life. I think we should, as Dr. Hopkins does, give much more time to psychotherapy than most of us are giving. I think if we could have adequate remuneration for a smaller list many of us would very usefully occupy our time in these ways. But I think this is a very complex question indeed. There are many factors and I think it would be a very brave man who would say exactly what are the demands patients are going to make of their general practitioner in five years' time.

Chairman: I think this will be a convenient moment to adjourn.

(The proceedings were adjourned for lunch.)

ON RESUMPTION

688. *Sir Hugh Watson*: Do you want to add anything to what we were saying before lunch, Dr. Cardew, or shall we proceed?—(*Dr. Cardew*): On the question of the pool perhaps we could just add one point to the answer I gave to Professor Jewkes. It is a very difficult question whether a pool is necessary. We feel a pool may be necessary from the point of view of the Treasury so that some annual commitment is known to the Government, that is one point of it. Of course the original method of assessing the pool was based on the population and it was only after the Danckwerts award that the new method was introduced, assessing it on the number of doctors. The original method of assessing it on the population meant in effect that as the rate of increase of doctors was greater than the increase of the rate of population the doctors were gradually losing ground. The introduction of the Danckwerts principle meant of course that the doctors kept their ground because it was based on the number of doctors rather than the number of patients. We see no objection to this and, in fact, we would like to adhere to this principle. We accept the proviso that Mr. Justice Danckwerts himself made that the number of doctors would have to be reasonably in proportion to the population. If it increased wildly that clearly would have to be reassessed and we would like to adhere to that principle. If the Royal Commission did not like that principle and wanted to depart from it, we would at least like the principle to be accepted that if a rate for the job was, so to speak, laid down by the Commission, there should be a regular method of review which would take into account the doctors' work he gives to the patients as well as other factors. In other words, medicine is a changing art and the amount of work which a doctor has to give to his patients is likely to vary as the years go by. So we would like that to be one of the factors to be constantly kept in mind in reassessing the amount. I think that is all I wanted to add, Sir.

689. *Professor Jewkes*: Under the present arrangements, since the central pool varies with the numbers of doctors, it is conceivable that the number of doctors may increase more rapidly than the population. In fact, this is what has been

happening, and in that case the doctors get the same money for less work?—Yes.

690. That is to say, the number of patients per doctor decreases, but since the central pool is determined by reference to the number of doctors, no doctor suffers. You want to keep that sort of minor premium in the system?—We think it is justified because we do not think that, in fact, it results in less work per doctor. What it really means is that it gives the doctor a little more time to give to each patient. I think we can show that ideally, if the finance was left out of it no doctor in his senses would choose to look after 3,500 patients; if he was going to give a full service he would probably put the number at something like 1,500 or 1,800. In fact, there is a big lag to be caught up with on the side of medical care. In America it was recently asserted that the optimum number is regarded as 1,000 patients per doctor. I noticed in a report recently published by the Derbyshire Health Centre in Manchester, which is one financed by the Rockefeller and Nuffield foundations, that four doctors concerned there said they considered the optimum number of patients was 2,000. There is a lot of evidence to show that doctors, if they were given the opportunity, would look after less patients. It does not mean they would do less work. It means the amount of work would increase as they had less patients.

691. *Sir Hugh Watson*: Perhaps we should dispose of one or two relatively small items. I do not want to belittle them in any way but they are relatively small. One of the matters on which you lay considerable importance is what you call various rates of morbidity. You mention it in nearly all the papers you have put before us. Would you like to say something about that?—Unfortunately there are not a great many facts available. But those that are available show that the differences of workload vary throughout the country—and I believe that the National Insurance scheme claims would bear this out. It does seem to us that in the areas of high morbidity which, by and large, are the areas which are unpopular areas for doctors to go to, usually the industrial areas in the north, the doctors have apparently to give most work for the same amount and we think there is a case for establishing differential payment, if it could be done

without too much difficulty. It would mean, of course, getting accurate figures of morbidity for all the areas of the country.

692. Yes, I think the view of the Commission is that this is a matter into which they could not delve, but they wanted to know your view about it. You mentioned that no effect has been given to one of the Spens recommendations about rewarding experience and special responsibilities in the G.P. service. Is there no method other than that to be derived from successful head hunting? Have you any solution to that problem?—No, Sir. We have gone into this at enormous length over the years and we have come to the conclusion that anything proposed would be unpopular with doctors themselves. Any method of assessing merit would give rise to awful internal difficulties in the profession. In fact, it is clearly nothing to do with degrees, the quality of service given, and it would be very difficult to assess which doctor was giving a better type of service. We like the idea of rewarding merit and encouraging good medicine but we honestly do not see any way it could be done, except in the one instance of doing it through expenses. That is, giving the doctors opportunities of practising better medicine and assuming those who have taken those opportunities would employ ancillary staff and give more time to their patients. Doctors will get a better reward because of this system we propose, but it would not be a system of selection on individual merit. Rather, it would be rewarding them by giving them the opportunity for practising good medicine.

693. I think you will agree that is a little off the point?—It is a little off the point.

694. *Chairman*: By saying you cannot see a way of rewarding merit you also cannot see a way of penalising those who really skimp their work?—Only by the way we suggest of expenses, of not allowing them to take on large numbers of patients while keeping low expenses. Of course there are certain basic standards by which doctors are required to examine their patients and do a proper job under their terms of service. There is the normal machinery of the Act to help deal with those doctors who do not do their job properly, but it is a fairly blunt instrument.

695. There are wide variations between the minimum, the critical normal and the maximum of the very conscientious chap?—Yes.

696. For instance, on maternity cases which you mentioned earlier. Does that apply there?—*Dr. Elliott:* Yes.—*Dr. Cardew:* We would like to make the point that whereas we know that there is this wide difference we do not think it is due to differences of goodwill, so to speak, in the profession—the desire to do a good job. It is simply that the circumstances over the years have been such that they have in a way forced a low standard on a certain type of practitioner in certain circumstances, whereas others who, whether by luck or by association with their fellows, have been able to practise medicine in good circumstances, have kept their standard rising automatically. We think there is a close association between the circumstances of the practice and the ability to do good medicine.

697. *Professor Jewkes:* Whilst you are on the question of merit I noticed in paragraph 62 that you say the M.P.U. are strongly opposed to the idea of a system of merit awards for general practitioners. Would you care to enlarge on that and explain why?—Simply for the reason that we do not think it is possible by any measurement we can think of to assess individual merit. We think it would give rise to appalling internal dissensions in the profession if you had local committees picking out individual practitioners and saying that one practitioner should have £X a year more. We do not think that any committee like Lord Moran's could do this job for general practice.

698. *Chairman:* While we are on this point do you regard the two branches of the service, that is to say the general practice and consultancy, broadly speaking as parallel and equal in status?—Yes, Sir.

699. That is what I anticipated.—Not as regards remuneration?

700. No, in status.—Yes.

701. A doctor should not feel that he was going into a higher class or lower class according to which branch he went into?—No. In fact, we regret very much that the present circumstances of general practice have often forced an inferior status on the G.P. in the sense

that he has not good diagnostic aids freely available. If he has a big list he is forced to refer too many cases to the hospitals. So he does become, by the circumstances of the practice, of an inferior calibre; but he should not be and it is very much against the interests of the future of medicine that he should in any sense be regarded as inferior.

702. And, of course, you know that on the hospital side with the system of merit awards and in other ways there are wide variations in remuneration, wider probably than on the G.P. side?—Yes.

703. Do you think that is a good thing?—We are going to give evidence on the hospital field. There are a lot of things we dislike very much about the present system of remuneration, or rather the levels of remuneration in the hospital field. We are going to give detailed evidence on that, and on merit awards. We are going to have a lot to say. We did not anticipate that you would want to hear about that today.

Chairman: We can probably get that in one of your later reports.

704. *Sir Hugh Watson:* Perhaps we could take fairly shortly the paragraphs from No. 34 onwards in which you deal with systems of remuneration. As I understand it, there are three possible bases, roughly speaking. There is the item-of-service basis; there is the salaried or sessional basis and there is the capitation basis. The view of your Union, as I understand it, is that ultimately what you think would be automatic, would be a sessional payment basis with health centres but that while doctors operate from their own chambers, so to speak, it is not practical to do that?—Yes, Sir.

705. And accordingly to use your own expression you aim at moving organically and gradually towards that. You think that whatever method of payment is adopted at the present time should be such as can be adapted to fit into a sessional payment system when the time comes. In other words, make the best of the capitation system meantime, is that right?—Yes, if I could add one sentence to that. We think that as the level of lists becomes nearer to the average, as it undoubtedly will have to over the years, so this tendency to think in terms of competition will get less as doctors work together in groups—either in

private groups or in health centres—and the opposition to a sessional basis will disappear. We make no bones about the fact, however, that at the present moment doctors would resent very, very strongly indeed the imposition of a salaried service. There is no question about that at all. We speak with certainty on that, on behalf of our own members.

706. In spite of that you do not think that the fact that you are paid a fee on a capitation basis just now is in any way implying that you are salaried?—It is not.

707. *Chairman*: May I say one word on the salary question? We have had some evidence from another body, as you may be aware, Dr. Cardew, which implied that the younger doctors were far less universally hostile to such a change than the older ones.—I think the reason for this is quite simple. The difficulties of getting into a practice are still very great, as you have probably already had evidence. It is exceedingly difficult for the surplus doctors in the hospital field—senior registrars, registrars—who have to leave that field to get into general practice. Naturally those people dislike the free-for-all present method because they see no security or future for themselves. Naturally they would welcome the security of a salaried basis. How many of them would give that answer five years after they were established I do not know.

708. But when you speak to the effect that doctors as a whole are dead against a salaried service you are really speaking on the whole for the young as well as the older ones?—I would speak for the ones who are already established in general practice.—*Dr. Faulkner*: The majority.—*Dr. Cardew*: A large majority.

709. *Sir Hugh Watson*: How would it make it easier to get into general practice if people were paid a salary?—I imagine it is always difficult to visualise a system which is utterly remote from the present system. But if the State undertook complete responsibility for providing general medical services for the nation, including the premises, presumably there would be many vacancies, as there are in the hospital field. A young doctor who left the hospital and decided to go into general practice

would apply to go into a health centre. But that is very remote from the present.

710. Yes, I think we might perhaps not pursue that.—I am quite willing not to.

711. *Professor Jewkes*: May I ask a question on the word 'competition'. It seems to me you feel that competition among doctors is a bad thing. May it not be that competition which takes the form of all doctors trying to emulate the achievements of the best is a good thing, as is competition in many other fields? Why should competition among doctors be so serious?—I am sure there are other members of my delegation who would like to reply to this. I would just like to say that we do not think that a system of trying to get the largest number of patients on your list is the best form of competition in medicine. Competition by all means if there was a way of devising competition for giving the best type of service, for doing the best type of research work, but not competition merely to collect a number of patients on your list because the evidence is overwhelming that the public is very poorly placed to assess merit. The reason which takes patients on to the list of a doctor I would have said, in order of importance, is the conservative nature of the patients, the fact that for years his family have gone to a particular house and they just go on going to that house because they have always done so and it takes an awful lot to shift them. I know this from when I was in practice in Bristol after the war. Patients used to come and see me from five miles away and I remember asking one of my patients why did he come to see me. It was highly inconvenient for him. I said: "You do not know me, you have no link with me, and in Bristol we have moved houses three times due to the bombing". He said: "I have always been to this firm." It was a meaningless answer but it was a very real attitude. There are other factors, like the superficial manners of a doctor; in one case they will appeal in another they will not. It is nothing to do with merit. I do not know whether my colleagues have anything to add about other factors which they know.

712. *Sir Hugh Watson*: It was suggested to us by some other body that one potent factor that directed patients to a doctor was the Rolls Royce.—It

might be so in private practice. I have not seen many in general practice.

That was solemnly suggested to us.

Chairman: It just applied to consultants.

713. *Professor Jewkes:* I thought that where a doctor's list increased that might be some indication of the energetic and conscientious fashion in which he was doing his work. But you do not think there is any link at all?—I generally think there is no link at all. I have heard cases of new doctors known to be good young doctors, well qualified, who have established themselves in a new area near an established practice where the standard was not too good and I have gathered that the shift was remarkably little from the big practice to the new practice. There is another factor and that is geographical convenience. It is almost the most important. Patients are often extremely lazy. I know doctors who have said they will not give up their premises and move 400 yards away because they know they will lose a great many of their patients in doing so. People will not go that little extra distance.—*Dr. Hopkins:* I think I can add from my personal experience. Despite my efforts to keep my list to less than half the allowed maximum—because I find I cannot fulfil all I want to do for patients if I have not the time—despite these efforts my practice has increased in numbers and I find the more patients on my list the less time I have to give to individual patients. I consider that my standard of service is reduced somewhat—and my practice is less than half of the allowed maximum. I keep it at this figure deliberately so that I can give patients time and I might add that in doing this I automatically limit my income.—*Dr. Elliott:* The other point is that all surveys of general practice, the Nuffield survey and the B.M.A. Hadfield survey, showed that the standard of practice was worse in industrial areas where the average number on the list, on the whole, was the greatest.

714. *Chairman:* Which documents are those?—Stephen Taylor's book on "Good General Practice" and the Hadfield report on general practice which the B.M.A. published in the British Medical Journal.

715. *Sir Hugh Watson:* Dr. Cardew, in paragraph 42 under the heading "The Doctor's Responsibilities" you

detail circumstances with which the Royal Commission are really quite familiar. You would admit, of course, that other professions have heavy responsibilities cast on them too?—*Dr. Cardew:* Oh, yes. We think the one detailed in (a) is important.

716. The last sentence of (a) is: "His life is one of constant anxiety". Is that really not just a little bit of an exaggeration perhaps? A doctor is naturally anxious about his patients. I do not suppose I ever had a higher regard for anybody than my family doctor, but he had his game of golf. His life was not one of constant anxiety.—*Dr. Faulkner:* If I may speak on this, I think it is the continuing responsibility that is the different factor. A doctor may, of course, appoint a competent locum to look after his patients while he plays golf but there are many patients who will not be satisfied with a deputy; who, rightly or wrongly, believe that their own individual doctor can give them something that nobody else can give and make continuous demands on him and on no other doctor in the Health Service. The consultant responsible for 60 beds in a hospital has his registrars and so on who take continual responsibility from him. He may, of course, at any time of the day or night take decisions of great importance. It is only the general practitioner, I should say, who has the constant anxiety. I do not think this is too strong. At this moment all of us here have continual anxiety for our patients. We have other people looking after them but we have at the back of our minds a feeling of responsibility for a large number of patients which we can never give up entirely. I do not think this is an exaggeration at all, Sir.

717. *Mr. Gunlake:* Does it in your view distinguish your profession from other professions?—*Dr. Cardew:* I do not know of any other profession where a wrong decision could have such important consequences. You examine a patient in the morning and you go away. Throughout the day you are wondering at the back of your mind if you have missed anything there. If it is a wrong decision it may have very important consequences, which I do not think you would find many professions have.

Sir Hugh Watson: I grant you the life and death element but this question applies to a high degree to solicitors and lawyers.

Sir David Hughes Parry: And to accountants.

718. *Sir Hugh Watson:* I constantly have in my mind "Was I absolutely right then", and I do not know for five years.—The consequences of any wrong action are not quite the same.

719. I gave you life and death.—And others, even injury to health due to wrong diagnosis.

Sir Hugh Watson: Enormous financial worry is also serious.

720. *Sir David Hughes Parry:* There is the case of the mining engineer.—Yes, a mining engineer would certainly be more comparable.

721. Even a train driver.—*Dr. Hopkins:* But these people are not likely to be called on at any hour of the night, any night of the week, to attend a patient who has collapsed and has some acute illness come upon him.

Chairman: I think you under-estimate the extent to which other people are called out at any time of the day or night.

722. *Mr. Watson:* It would not be an exaggeration to claim that a mine manager or a mining engineer of a big mine has (a) more constant anxiety than any doctor and (b) is called out of bed more than any two doctors.—*Dr. Cardew:* I hope he is remunerated on that assumption.

723. *Mr. McIntosh:* Is there not here a confusion: it is the effect of the anxiety on the individual entirely and I do not think any profession can claim any particular amount of anxiety. I can imagine a person who has quite a light responsibility but worries about it enormously. That is the point, surely?

—That is true.—*Dr. Elliott:* There is another point that according to our terms of service as general practitioners we have responsibility for our patients all the time, and though we might arrange various deputy arrangements until very recently we were responsible even for the wrong doings of our deputies. I do not think there is any other section of any profession, which equals our responsibility for 24 hours a day and night for what happens to our patients. This is a terrific cause of anxiety. I do not think we should enter into relative merits of anxiety of different people but to take an example, we have had a terrific influenza epidemic. All of us

general practitioners have been working extremely hard. We know other people work hard too. On top of the ordinary influenza we got the complication of bronchial pneumonia which was very worrying. The hospitals were not able to deal with all the cases and truthfully I personally, since I have been in practice, have never had such a prolonged worrying time than during the last three months. I personally felt very bad because of all this anxiety I have had in the last three months.

724. *Chairman:* I think again, Doctor, that you do not quite in your profession give full account of the extent to which this kind of situation arises in many other walks of life. It is not an unusual phenomenon but we fully appreciate that it is a factor in the doctor's life.—*Dr. Cardew:* We did not feel we were called upon to make a relative assessment. We felt we had to put the thing down as we saw it and leave it to your judgment to make the comparison.

725. *Mr. Guniak:* I wonder if without comparing the medical profession with others I might ask the question in another form. The anxiety in the medical profession, as I see it, arises from two causes. First of all, a crisis, a collapsed patient, something of that kind where something has to be done very rapidly. There is also the long term anxiety of a difficult case with complications and you may wonder if you have made a right decision and so on. Is it fair to say that in that last type of case, life is not quite so difficult as it was, say, 20, 30, 40 years ago with modern therapeutic methods and with easy access to hospitalisation; that that form of anxiety is less than it was?

—*Dr. Faulkner:* It is true to say that the responsibility has changed. While we are less anxious, say, about the case of acute pneumonia which we can treat with penicillin . . .

726. I was going to ask about that.—But at the same time our territory has increased because we have more seriously ill patients at home in general practice than we had before because antibiotics generally have allowed us to retain patients in their own homes. And, of course, the increase of other facilities, the domiciliary visits which you will know about, the expansion of home nursing, the home help, and direct access

to X-rays have all tended to mean we have more seriously ill patients. The range of cases which we can treat in general practice has increased considerably, so I think that would offset the actual fact that we have more in our armamentaria to treat these serious types of illness.

727. *Mr. McIntosh*: Would you say you had as much night work now as you had before?—I think perhaps *Dr. Walden* had better answer that.—*Dr. Walden*: I do not think night work has altered very much. Perhaps patients are a little more considerate in ringing and asking for visits whereas before they would have liked you to have called. I think that is the only reduction in type of night work.

728. *Chairman*: Partnerships help a bit?—Partnerships help a great deal, Sir.

729. *Mrs. Baxter*: In fact, what you are saying is something quite outside our consideration has come to your aid, namely the extension of the telephone service?—Not only the extension of the telephone service but the education of the population.

730. But many more people now can use the telephone sensibly?—Oh, yes.

731. *Sir Hugh Watson*: When you say education of the people, *Dr. Walden*, the doctor must play a large part in that?—He plays a very large part in it.

732. We have had evidence that the public are gradually becoming aware that they must not abuse this Health Service?—Yes.

733. And while it was, in fact, natural that they should all rush to the doctor when it was first introduced that is substantially less the case now than it was at the outset?—It has changed slightly.—*Dr. Cardew*: I do not know if it has. You have two influences to bear. One is the one you mentioned, also a great deal of propaganda from the Ministry and from the medical profession that the patient must go and see the doctor earlier. Even on the television there has been a regular advertisement in the last few months "Go and see your doctor".

734. That would he in the surgery hours?—"Go to bed and call the doctor"—a whole range of advertisements has said that.—*Dr. Hopkins*: And the

patients do.—*Dr. Cardew*: So you have influences both ways, both to see the doctor earlier.—*Dr. Faulkner*: The figures have not changed in our knowledge very much.

735. *Mr. Watson*: Would it be fair to say that the number of consultants now available compared with 20 years ago and the demand for the domiciliary visit has encouraged the general practitioner to hand over his really had cases to the hospital consultant? You talk about constant anxiety?—The practice now, wherever possible, is to keep them at home.

736. But surely you bring in the consultant, there is an arrangement for that?—*Dr. Cardew*: That does not lessen the work for the G.P.

737. I am not saying that. Surely it is an asset to the ordinary general medical practitioner which he did not have twenty years ago?—Certainly.—*Dr. Faulkner*: But the proper use of the domiciliary consultant service is to try and keep your patient at home, getting advice on how to have the patient at home. So twenty years ago some of the cases we called out consultants to see we would have had to send to hospital; they might have died before we could get them to hospital. But we think the service, properly used, allows us to keep more patients at home and therefore although the consultant shares some of the responsibility for treatment, in fact we have a continuing responsibility for that patient, for perhaps three or four weeks, whereas previously we would have sent them into hospital. I think that also works both ways.—*Dr. Hopkins*: It does, in fact, increase the work because if I have a patient with pneumonia I can either send the patient into hospital or treat at home. I get the same capitation fee either way. But since I like to treat my own patients I keep them at home where I can. I call in a consultant certainly for his guidance but, in fact, it increases my work because I will have to visit that patient perhaps once or twice a day for a week or ten days whereas otherwise I could have just sent him into hospital and completely lost contact with him. In fact, this increases the amount of work one does.

738. *Sir Hugh Watson*: I think the Commission appreciate to the full the

responsibility and all that goes with it of the doctor's occupation and the honourable respect in which he is held in the community. May I turn now to the question which you find so difficult and which we all find so difficult? It is dealt with in paragraph 47. I am not sure whether I am encouraged or not by the last sentence in the memorandum which you submitted—the additional memorandum on the payment of expenses. In the last paragraph it says:

"The Union wishes to state that it is not concerned in detail with the actual mechanics of any scheme for repaying practice expenses. In any case these mechanics would have to be the subject of a detailed study and negotiations between the Ministry of Health and the profession. It is concerned, however, with establishing the principle that the repayment of practice expenses should be divorced from net remuneration and that expenses should be repaid on a realistic basis."

At the present time, as we know, as it was put to my learned Friend, it is recognised that a doctor in earning a fee of two guineas spends one guinea, so he has, in fact, three guineas. That is what it works out at, is it not?—*Dr. Cardew*: Yes.

739. But the trouble is that while "Dr. Watson" incurs the expense of one guinea he is an entirely mythical and legendary figure and Dr. Cardew who is a public spirited and generous person spends 45 per cent. or more; Dr. Faulkner would be much more careful, he spends 26 per cent.; he does not employ the proper ancillary staff, he keeps his surgery in a much less proper way. We have certain figures of these matters which you have probably seen. They are contained in the review which was prepared by the Inland Revenue for the years 1952 and 1953 and I have the one for 1953. Have you the figures?—I saw them at the time but I have not looked at them for a very long time.

740. Of course we deal with averages.—Yes.

741. There are various groups beginning with an urban single-handed general practitioner with under 1,000 patients and going up to a partnership with four or more principals in the country and the result is that the averages vary from 44 down to 29.5. As I understand it you

maintain that the fact that "Dr. Watson" does not exist is an encouragement to many doctors, or to put it the other way, is a deterrent to any doctor from spending on premises and so on what they ought to spend and the people who spend what they should spend rather hold back? You have propounded various alternative schemes from time to time. You had the 1950 scheme, the 1951 scheme and then the third scheme. You have dropped the 1950 scheme. There is the 1951 scheme. You still feel that ought to be explored further?—We would prefer the 1951 scheme of all the schemes, if it could be operated.

742. In your note you say you do not wish to go into the mechanics of this case. I am sorry to have spoken so long but I am very puzzled about it. How exactly do you stand?—Quite frankly we are protecting ourselves with this. We do not feel that we are in any position to work out a scheme in the utmost detail which would be acceptable to the Inland Revenue, to the Ministry of Health and to the medical profession. All we can hope to do is to try and devise in general, but in as detailed terms as possible, solutions to this problem and we have explored a number of avenues which I think might be helpful. But we do not want it to be said that because some little flaw could be found in one of the schemes that the whole idea should be thrown aside. We attach the greatest possible importance to the acceptance of the principle that the present method of dividing expenses is against the doctor's interests and against the public interest and should be remedied.

743. I do not think I need to go further into the mechanics of this thing. You and I both know perfectly well how it works. We know there are two different things involved. One is the question of repayment to the doctor of what are, in fact, only notional expenses, and the other is the ability of the doctor either by himself or through his accountant to recover income tax on what he has, in fact, spent. That is the whole problem?—Yes. At the present the doctor is actually discouraged from spending money. There is no question at all in regard to his ability to do good medicine or give good service to the public and that is the principle we want

to reverse. A way should be found to encourage the doctor to undertake expenses which are in the public interest and in his own interest.

744. I know that the difficulty is how to bring that about. The Commission now has to enquire into remuneration and you may well say to us that remuneration means good remuneration and therefore the way in which expenses are dealt with is most important?—That is what we do say.

745. Do you suggest that the Commission should take it as a fact that this thing does operate in the very unfair way that you suggest, or how would you propose to establish it?—Well, Sir, we have a number of individual cases which we can bring to your attention, either privately or however you wish, to fortify this evidence, because it is an unassailable fact that the expenses of practitioners vary very widely. Even the published figures which you have quoted show that. And yet they are all repaid on the basis of 33·4 per cent. at the present time. Even some groups are apparently favoured as against others, but we would not accept that those groups by any means are the representatives of the individuals within the groups. The extremes are much wider than those quoted there.

746. The Commission have been having some education in the last week and it is suggested to us that it would be worth while to go deeper into this instead of having averages; that we should look into these various groups and find out exactly what we are talking about.—And even take a random sample of certain individuals.

747. *Mr. Watson:* Take the case of a doctor who has been in practice for a long time and has a well-established practice. He takes in a young partner and gives him one-third of his practice. This young doctor might do more than half the work in the practice itself. How would this expenses principle work in that case?—I think this is an entirely different question, the division of net remuneration between partners. How the expenses would vary is incalculable. It would depend on so many things, on the local conditions, the number of houses, all sorts of factors. But the general principle is, I think, unassailable, that there are certain areas of the country, the industrial ends

of towns, where it is very cheap to run a practice, where traditionally patients do not expect a very high standard of service because they have never known anything better, where a doctor is allowed to run a very low practice from his surgery and have a very low expense ratio indeed. He may gain as much as £700 or £800 a year because his expense ratio is low. He is able to benefit from that. To me this is clearly against the public interest, that a doctor who is giving a low standard of service should have money added to his net remuneration, whereas a doctor who is going out of his way to provide a good service should lose.

748. *Professor Jewkes:* On the question of principle—let us leave on one side the details—is there this kind of danger in connection with your scheme? If doctors knew that their expenses were going to be reimbursed in full might they not spend too much on their surgeries?—This is the problem we tried to face in the 1951 scheme. We did reckon that doctors, being human, would get as high expenses allowed by the tax authorities as they possibly could. In other words, their accountants would naturally advise them as to what they could put in as legitimate expenses, and of course every doctor will try for that figure to be as high as it can, because he does not pay tax on it. We do not think there is much danger in increasing the normal items of expenditure because the Income Tax Inspector has already seen that they do not indulge in extravagances in their practices which could not be justified. There are certain instances where that would not apply, I suppose motor car expenses. It would be difficult for an Income Tax Inspector to say that a doctor was not entitled to buy a Rolls Royce. And it seemed to me it would clearly be against the public interest to encourage the doctors to do that. So certainly in these items we have tried to devise a protection to the public, so that a reasonable standard should be laid down. On the question of employment of a receptionist for example, we think it would be possible for the Ministry to say "We think that a receptionist could be employed for a certain size of list—a whole-time receptionist", and the doctor would be fully rewarded for that. But if he had less than a certain number he would only be entitled to employ a

receptionist half-time. That is for repayment in full. Of course if he wished it he could still employ a whole-time receptionist and put it in against the income tax. In other words, there would be a strict limit on the amount repaid by the Ministry which would necessitate a local committee to do some investigation.

749. I see. You would contemplate a local committee establishing, say, minimum standards, and those minimum standards would automatically be accepted by the Inland Revenue?—Yes, exactly.

750. If you do not have that arrangement do you not run into the difficulty that you have tax inspectors deciding what are technical matters medically?—That is so now.

751. Yes, they do now. But of course the problem might become more acute if in fact you were being reimbursed 100 per cent., because naturally most doctors would want to spend more under those conditions on their surgeries, which in fact you think is desirable?—So long as it is done within the area of public interest, yes—within reason.

752. *Chairman*: Which is to be defined how?—It would have to be defined by a local committee. There would have to be a joint committee which would have to justify expenditure on practice premises. In other words, let us say, a local practitioner in Birmingham would say: "It is three years since I had my surgery decorated", and apply to the committee and put an estimate into the committee for doing it. The committee might say: "No, we do not think it is justified." He could still do it and get the income tax off it but he would not necessarily get the return in full.

753. I think the Cohen Committee suggested that not enough now is being spent on surgeries?—I sat on that committee, but I forget the conclusion.

754. *Professor Jewkes*: The M.P.U. is certainly suggesting it?—Yes, certainly.

755. How are you going to make sure that there will not be big local variations?—This is always the difficulty in things of this sort. I imagine you would have to have a central committee which would lay down guidance

either in the form of an instruction from the Ministry to the local Executive Councils or by some professional body which would lay down some agreed central standards. Then you would have to see that the local bodies applied those standards. I suppose it is inevitable you would still get some local variation, but you cannot get everything perfect in life always.

756. You must not think I am opposed to your scheme, Dr. Cardew, but once you have a national scheme with national standards administered by local bodies, do you not get an extraordinarily rigid system? For example, is it the case among doctors, as it is among some other professions, that some people like working with a lot of equipment and some people like working with little equipment? How are you going to allow for that kind of difference?—*Dr. Faulkner*: Surely you are not going to get any scheme that completely covers this type of thing. All we are asking is that some of the anomalies in the present scheme should be removed. We envisage certain broad divisions, certain allocations, a certain number of receptionists, a certain number of secretaries, perhaps a certain number of other ancillary staff in some isolated areas would be accepted. There would be certain standards laid down, and once the preliminary work was done it would be administered automatically. And then the special applications: if a doctor said: "I want to do minor surgery and I am 40 miles from the nearest hospital. I therefore need a nurse. I need to maintain my equipment", it would be a special case, and he would justify it to his colleagues, to the representatives of the local medical committee, that he needed that particular thing. In addition to that there would be a certain number of people who perhaps could not justify their desire to have six secretaries instead of two, or to work on an expense ratio which would seem to their colleagues to be fantastically high. They would still be entitled to what was the generally accepted figure, the standard laid down, and they would still have to meet any addition from their own pocket. But this does not detract from the fact that this scheme would actually encourage genuine expenditure in providing facilities where better medicine could be done. It could not make better medicine be done but we believe it could materially alter the

circumstances and allow better medicine to be done.—*Dr. Cardew*: I think one should add it is equally important that it would not allow a doctor who grossly underspent to benefit financially from underspending. I think that is just as important as the other side. The doctor who spends £800 a year less than he receives would no longer get the £800, he would only get the lesser sum.

757. *Sir Hugh Watson*: My friend "Dr. Watson" pays tax on £2,222. It is probable that you do not, you see. You pay tax on £3,333 less what you spend; is that not so?—Yes.

758. He pays tax on £3,333 and then he has got to go to the Inspector of Taxes and put forward his claim for expenses, and to the extent that he cannot support the claim for expenses he has to pay income tax.—Yes, I think we did make this point clear in our evidence, that the anomaly to which we have drawn attention if it extends over an area like that is actually reduced at each end because the doctors who gain by the operation do not gain the total net amount because half of it comes off tax; and the ones who lose at the other end do not lose the total amount. So actually the anomaly is not as wide as it would be if it was not for the tax element.

759. On this question of having all these expenses proved by a committee of some kind or another, in the expenses claim which you submitted with your second memorandum there appear to me to be about 16 items which will have to go before such a committee which could not be admitted without prior approval.—Sixteen, are there?

760. I think so—domestic help, maintenance repairs, laundry and dry cleaning, expenses of branch surgeries . . . —All those would be admitted, Sir.

761. Would they?—Yes, because the figures included under these headings should be those submitted to and accepted by the income tax authorities.

762. And in your view they would be repaid through the committee? They would be taken out of the realm of income tax altogether?—No, Sir, no.

763. On your view, as I understand it, the doctor will be paid £2,222, and he will be repaid his legitimate expenses?—Yes, out of this central expenses pool.

764. So that these figures will still have to go before the Inspector of Taxes?

—Oh, yes, because in submitting his claim for payment of his expenses the first requisite step is to submit his claim, his approved claim, an approved and accepted claim, to the income tax authorities.

765. *Chairman*: Why?—Because that is a preliminary check of the greatest value. If an Inspector will not accept a large number of items as proper to the practice, then that is the first check, which we think is a very valuable one; it is one already applied.

766. *Sir Hugh Watson*: I should have thought, Dr. Cardew, with great respect, that if the local medical committee, or whatever it is called, went with their knowledge and certified that they were prepared to advise the Ministry to repay to the doctors certain items, then that takes it out of his income tax account altogether.—Yes, I see the point. But it does mean much more detailed work by the committee.

767. I think that is what you are running into.—What we were suggesting was that the Income Tax authorities, so to speak, acted as a guardian of the public purse already, and we continue to use it for 90 per cent. of the scheme. It is the basis of the expenses pool now. The £23 million which is repaid to the doctors is in fact this item approved by the income tax people.

Sir Hugh Watson: That may be, but I am not sure that you follow exactly the logical consequence of where you are going in this. I think you are going to increase the amount of paper work enormously.

768. *Chairman*: I think you are giving the Inland Revenue something which has never been its job—assessing the cost and justifiable expenditure on something that they are never going to touch.—Sir, they already accept this obligation.

769. They do now, because it is now part of your income. You return a gross figure now and you try and establish that some portion of it is a legitimate expense because it was a necessary business expense. But in future you will not be doing anything of the kind. You will return your full net remuneration and then say: "Will you please act as a

certifying authority to say that this expenditure is reasonable when, having no effect on the Inland Revenue at all, we will then send in a chit for repayment in full." It does not ever touch the Inland Revenue.—It need not

770. It does not. It will not. They have nothing to do with it on that basis, unless I have quite misunderstood it.—I think you have misunderstood this, because at the present moment the amount of the £23 million repaid to general practitioners—in other words, their gross remuneration—is determined by this very factor, by the amount which the Income Tax Inspector will allow on the individual case.

771. I understand that the £23 million is determined on a periodical assessment of the average percentage.—Of the actual amount returned by doctors in expenses, yes. So in fact the amount of this sum is determined by multiplying up the individual claims allowed by the Income Tax Inspector.

772. *Sir Hugh Watson:* That is so as it happens at the moment, but it seems to me that various points flow from that. In the first place we have been told that there is not uniformity throughout the country in the way in which Inspectors of Taxes deal with these claims.—I think that is true.

773. Secondly, if, as the Chairman suggests, your system were adopted and you were to have a committee which approved expenditure of doctors and authorised it to the Ministry for repayment, that would take it out of the category of income altogether, and it would no longer come under the jurisdiction of the Inspector of Taxes, because the doctor would get his £2,222 and he would also get in due course—mind you, it would take some time before this machinery of yours would be operative—his repayment of expenses.—That is exactly what happens now, is it not, at the present time?

774. Yes, but now the average, the normal, doctor is assessed for income tax on £3,333 and he has got to justify to the Inspector of Taxes certain expenses.—If I might stop you. The only way the figure of £3,333 is known is by finding out what the £1,111 is—by finding out what to add to the £2,222 to make it to £3,333.

775. I agree, but then, you see, to that I answer that it is very probable that if the question of expenses was dealt with on a uniform basis by committees who knew their subject in more detail the doctors might even come off better and certainly they would get their expenses repaid. They would not be assessed for tax on them at all. At present they are assessed on £1,111 less what they can justify; that is the position?—Yes.

776. *Chairman:* And it may be a good deal more than £1,111?—Yes.

777. And in fact often is?—Yes.

778. It may be more?—It may be more or it may be less, yes.

779. *Professor Jewkes:* Apart from the detail, is this correct, Dr. Cardew, that the £23 million we have been discussing is the actual expenses that have been allowed to doctors as a result of the Inland Revenue survey?—Yes.

780. And you are really suggesting, leaving the detail on one side, that instead of distributing that £23 million in a standard percentage to each doctor's net remuneration you would like to distribute it in proportion as doctors incur expenses?—Yes.

781. You do not care how it is done as long as the use is more rational?—We would like to suggest in one sentence that you repay doctors' actual expenses, but unfortunately we have had to try and find safeguards because we knew the comeback would be that it would be an encouragement to doctors to spend more.

782. But you are rather suggesting in your scheme that certain sums should be passed on which do not really come in the form of income and therefore not under the purview of the Inland Revenue; that is your suggestion?—I am sorry, I did not understand that last question, Sir. What sums particularly?

783. In so far as you have a system by which certain expenses of the doctor are completely reimbursed they do not count as income to the doctor at any stage and therefore the Inland Revenue has no cognizance of them. That is our difficulty on this side.—*Dr. Walden:* The intention is that the £23 million be distributed more equitably.

784. You are assuming, Dr. Cardew, that that figure would be the same—

£23 million?—*Dr. Cardew*: I think to be fair it would be larger.

785. *Chairman*: I think, *Dr. Cardew*, at least it could not be a pre-determined sum. You cannot have 600 Tax Inspectors assessing everybody individually and hoping they will arrive exactly at the pre-determined total of £23 million.—There might be a case of leaving the Tax Inspector entirely out of this if one could actually repay expenses on a local basis.

786. Would it then be suggested that you had, in effect, a whole-time salaried service?—I hope not, *Sir*. This is nothing to do with remuneration. It is solely money spent on behalf of the practice.

787. How would you differentiate between that part of the work that was outside the National Health Service—for instance, on private account, which presumably involves a certain amount of expenditure?—This is exceedingly difficult. The only way we could think of is to assume, which I must confess is not necessarily justified, that the expense ratio for the private part of the practice is the same as the expense ratio for the public part. I do not think you could have two different expense ratio rates. You would have to ask a doctor to declare his total sources of revenue from the three sources, from the local Executive Council, from private practice, and from that part which is not susceptible to expenses at all—fixed appointments in hospital, where you would not normally be allowed to put in for expenses. Then you would have to establish the ratio, the proportion which applied to the local Executive Council, and repay that proportion to expenses.

788. I feel sure that this is a very difficult subject to which you have given thought over eight years now. Any more thought you can give to it might be worthwhile.—Yes.

789. *Mr. Gunlake*: Are you satisfied that this would really be in the interests of the medical profession? Let us take an example. Take, for instance, the carpet in the doctor's consulting room, assuming that he has one. Under the present arrangement if it is replaced I imagine there would be little difficulty in getting a suitable tax allowance from the Inspector. The bill for the carpet could be produced to the Inspector and

would probably go through in a reasonable way. Under the kind of system you have in mind, as far as I can see, there would have to be a Ministry circular saying that a doctor should be allowed to have a new carpet in his consulting room not more frequently than, say, once every 17 years. That kind of arrangement would result, would it not?—That was why we were anxious to keep the tax man as the break wherever we could, rather than the committee, because you take pot luck as to whether the tax man happens to be a favourable one or not—as *Sir Hugh Watson* said, they do vary in different parts of the country. You do take a chance. With a committee it might be very rigid, I agree. We only wanted to introduce the committee for such matters as receptionists and a few items like that, perhaps three or four items.

That is why I raised this question, because the discussion appeared to be going at one stage rather in the direction of this kind of thing being done centrally and being taken out of the Inspector's hands on the grounds that it would no longer be a tax matter. I wondered where that would lead you.

790. *Mr. Watson*: In studying this complex problem have you come across any other profession that has this concession you are seeking?—I do not know of anyone who lives under this extraordinarily anomalous position.

791. It is only applicable to your profession?—As far as I know, in any business or other enterprise if you incur expenses legitimately in doing your job you get repaid; if on the contrary you do not, then you do not get repaid, but it seems to work in the opposite direction.—*Dr. Faulkner*: I believe wardens of approved schools used to be paid on this basis and it was found to work so unfortunately that the scheme was abandoned, but I have been unable to find anyone else in any kind of State service who is paid by this very strange method.

792. *Chairman*: May I come back to the time when you were self-employed people earning entirely private fees? At that time you presumably established a claim for expenses. You spent what you thought was right and all you got back was the tax on it.—*Dr. Cardew*: Yes.

793. Is that the position you want to find yourselves in now, as though you

were fully self-employed, or not?—It is a difficult one to answer. It is certainly not the position we want to get to.

794. It is not?—Do you mean when a man was entirely in private practice? Then he charged whatever fees he liked and put in his expenses, and he spent on his practice whatever he thought was desirable and he got a tax relief.

795. Presuming it was reasonably spent?—Yes. That is the position we want to get to, namely that the individual practice should get the benefit of whatever they spend.

796. For tax purposes?—For tax purposes. It is difficult to make the comparison because a private doctor before the Act merely put up his fees if he wanted to get more money to pay for his improvements to his practice, but we cannot do that; we cannot touch the total level of fees.

797. In those days the fees produced what was really the equivalent of the gross income before expenses.—Yes.

798. The present scheme is to some extent designed to produce that, is it not? You are given an average amount of expenses on top of the net amount to produce a gross amount?—Yes, that is quite true.

799. And then you spend whatever you choose or need or can justify and you get allowed that expenditure back.—Yes.

800. And the rest comes out of your own pocket from the gross amount, not the net amount.—Yes.

Chairman: Which is the position that would have been if there had been no scheme.

801. *Sir Hugh Watson:* Except only that you are subject to an average?—Which is the very part we are objecting to.

802. I think the first part is relevant to the point, but the real thing that hits you is that you are deducting the expenses you incurred to pay somebody else?—Exactly, that is what we want to correct. If we can find a simple way of doing that we shall be satisfied.

803. *Professor Jewkes:* How far do you think, serious as this anomaly is, it is lessened by the loading? There was always some idea that the loading would tend to settle the kind of difficulty you have in mind.—We think it does to

some extent. As we pointed out the maximum benefit of the loading is £200 a year to any practitioner. Even if you take the case where he benefits most, £200 is the utmost; whereas we can show you practice figures where individuals lose £700 or £800 a year due to this anomaly of expenses.

804. But the loading is in the right direction.—Yes; we think the loading is justified on the net remuneration quite apart from expenses.—*Dr. Hopkins:* But the loading does not prevent the anomaly of the man who might not spend any part of the expenses he receives. He receives a proportion. He does not employ a secretary, does not have the ancillary services to pay out of this money. So he is in pocket by that amount.

805. *Mrs. Baxter:* To check that would be one very definite incentive?—Yes.

806. *Mr. Gunlake:* Could we establish the magnitude of this? The argument is that all of you are allowed expenses on a 33.4 per cent. basis. If there is a bad doctor who keeps his surgery in a bad condition he would spend less as an individual. Now, the lowest expense ratio to which you have referred in your own memorandum on page 106 is 25 per cent.; so that particular individual to whom I am referring would be spending 8.4 per cent. of his gross remuneration less than perhaps he should be if he were an average doctor. Now, .84 per cent. of £3,333 is about £280, on which he would be taxed—and surtaxed at that kind of level. It appears to me therefore that the pitch of this thing as between the worst kind of doctor that you yourself envisaged and the average doctor is of the order of £150 a year net.—*Dr. Cardew:* If you put it that way I would agree, but unfortunately you omitted to apply this example, not to the doctor with 2,200 patients on his list, but to the doctor with 5,500 patients on his list and with an assistant at one end of the scale, and at the other end of the scale a doctor with 1,000 patients, where £200 at the lower end—the wrong side—would make all the difference. At the top end it may be not £150 a year but anything up to £1,200 less the tax element.

807. You did mention a figure of £700 or £800 earlier on. That is the £1,200 less tax?—Yes. So in fact you may

get a doctor at one end of the scale undeservedly getting £800 more than he needs, or more than he deserves; and at the other end the doctor who is desperately trying to do a good job of work being penalised for doing it.

808. *Sir Hugh Watson*: Actually, the case which is nearest to your 50 per cent. on the figures given by the Inland Revenue for 1953 is the case of a doctor having over 3,000 patients with one or more assistants. The average for him is 44.39, but a good deal of that is the salaries of his assistants.—I agree.

809. You mentioned a moment ago the maximum loading was £200. Is that right? Is it not £500?—He receives £500 but money was made available to create a loading pool instead of being used to put up the general capitation rate, and you will find there is a difference of the maximum of £200 to any one doctor.

810. *Sir David Hughes Parry*: Could we put it this way? What we are trying to arrive at is a scheme which involves three or four allocations, first of all the payment to the doctor of the actual expenses incurred by him. That should be repaid to him not by any pool at all, and that should not be liable to income tax, but would be determinable by the local committee, perhaps controlled or directed or advised generally centrally; and it should be accepted presumably for purposes of income tax, as the actual reasonable sum which ought to have been allowed if it had been assessed?—I think that is very fair.

811. And it is really an administrative problem to get that agreed between the Minister of Health and the local taxation officer or the Inland Revenue authorities?—If I may make one small addendum to that, I do not think in law it would be necessary for the sum agreed to be repaid to the doctor to be exactly the same as the actual expenses incurred because one knows in business one could have an employee to whom you pay £500 a year for expenses and say: "You must justify this yourself to the Income Tax Inspector". The Inspector comes over and says: "What were your expenses?" You receive £500 which you claim to be tax free on expenses, and he has to justify that. He may not be able to justify it exactly. So that is the analogy. I think, where you have an employer

paying what he thinks right and the employee having to make his justification to the tax authorities.

812. I can imagine the Revenue authorities saying they are prepared to recognise this provided it does not exceed a particular percentage of the amount that is received by that particular doctor from the pool. It may very well be that they would put on a limit of that nature?—Yes.

813. *Sir Hugh Watson*: You see, Doctor, if you do what Sir David suggests, which you said is a very fair summary, you are then really putting the doctor in a much better position, not only than he was before but in a much better position than any other profession, because not only are you saving income tax on what you spend but you are actually been repaid what you spend.—You are now, Sir.

814. Only notionally?—Yes, but if the £23 million was repaid fairly in actual terms it would be a complete repayment.

815. You are complaining that the incidence of it is unfair?—Exactly—the distribution.

816. Yes, its distribution and therefore the incidence on the individual doctor.—The principle is already the same. You are getting back exactly what you claim if you are the exact average.

817. *Chairman*: But, Dr. Cardew, at the present time every individual doctor has some advantage in trying to economise, or at least to decide on the merits or otherwise of spending this money to improve his practice and look after his patients better. If he is able to economise he gains that advantage, does he not?—Yes.

818. Under your system he would have no conceivable incentive to economise because presumably if he spends money improving his surgery and waiting rooms he is just improving his practice potentialities in competition with other people, and he will do that without any chance of it costing him a penny.—That is why we have introduced to the committee the concept of the check, because we believe the first operation is against the public. I think it is perhaps in the interests of the Treasury; viewed from the service angle it is against the interests of the public. In other words, to give an inducement to the doctor to

run his practice as much on the cheap as possible is against the interest of the service, we think. But we can accept the other point you make, that you could not give an unlimited inducement to the profession to spend.

Sir David Hughes Parry: You want to have some control because the worst type will be influenced more by the economic benefits than by other factors.

819. *Chairman:* But, Doctor, to run your practice properly and spend a reasonable amount of money on it is likely to lead to a better list of patients, to a better competitive position in the long run, is it not?—We do not think, generally speaking, that this happens. In industrial areas particularly, patients come anyway. There is only one doctor who is close by. They are used to going there, and they are not used to a decent standard of medicine. So we do not think this is by and large a very big factor. A doctor who has set up and spent £5,000 on his house and equipment is not going to get a reward from an added list except in the very remote future. But I think it can be shown, and I hope the Commission will read the recent report by the Darbshire House Centre, where they show—and I should think it is fairly general—that the benefits of good medicine practised in a group have resulted in a referral rate to hospitals two-thirds of the national average. Also, curiously enough, and I cannot explain it, the number of their patients per thousand in hospital at any one time is about two-thirds of the national average. It would tend to look as if when you have a practice and can do good work and have the ancillary help, you tend to save public money.

820. There would be less hospital treatment and fewer consultants?—*Dr. Faulkner:* I think, in answer to your original point, that it certainly would be possible to show an actual saving—obviously this is guesswork. There would be a tendency for a certain number of doctors who are at present spending less to spend more on equipment, but in all the groups that are spending—not the health centres where these things are provided from other funds, but in all the group practices—they employ nurses, receptionists, and in our own case, for example, a physiotherapist, out

of their own remuneration; they are quite definitely saving the funds of the Regional Hospital Board. We are quite definitely treating, giving physiotherapy to cases in general practice, to cases which we would previously have sent to hospital. And I am quite certain that a practice which is organised along these lines not only deals with more minor surgery, with more psychotherapy, physiotherapy, hospital social problems, almoning, and so on, but also tends to keep more patients at home; tends not to send patients to hospital as often as the very overworked, single-handed practitioner—with a large list in most cases—simply because they are organised, they have got ancillary staff, they do not have to spend their time on accountancy and the hundred and one things which the single-handed practitioner with inadequate staff has to do. I believe one could show by a survey of the group practices of these centres an actual saving in all of them, in the same way as suggested by the figures from Derbyshire House—*Dr. Hopkins:* I would say, apart from the group practice, the individual practitioner can also give this standard of treatment if he keeps his list low. In a survey of my own practice over a period of three years I estimated the number of patients I referred to hospital was a much lower figure than the national average; but again only because I pay out of my own pocket a secretary and a receptionist, which expenses are much more than I am allowed according to the number on my list.

821. Would you regard an assistant as an expense for this purpose?—*Dr. Cardew:* No, Sir; this is another problem. I think this really should be regarded as a separate problem.

822. *Sir Hugh Watson:* I think the Chairman means in regard to this one question, would you regard the assistant as an expense for this purpose?—Yes, Sir, we would regard it as an expense if allowed. We have stated that, have we not, if approved by the committee?—*Dr. Hopkins:* If the number of patients make it reasonable.—*Dr. Cardew:* For a limited period.

823. *Mr. Gunlake:* I think at one stage you said, Doctor, that this system resulting in anomalies as between one man and another was not found in other professions. I wonder if that is so. Take,

for instance, the architects, some of whom receive fees on a fixed scale, so that all architects doing that kind of work would be getting the same gross fees. So it would therefore lie within the power of individual architects to take more money home in the pocket by spending less on their own premises. Yet one does not hear of complaints that architects keep their consulting rooms in bad condition, and so on. The same, I think, would be true of other professions. Are these complaints of bad surgeries in fact confined to industrial surgeries in the medical profession?—

Dr. Walden: I think there are two questions there. The first question concerns the architects and the money they earn on a fixed rate. Surely it is only a small percentage then, not one hundred per cent. of their work. And the answer to the question about the industrial practice is—no, they are not the only ones.—*Dr. Faulkner:* Presumably the only architects we can compare are those employed in State or local authority services.

824. I thought the suggestion that had been made was that members of other professions could in fact reimburse themselves for the money they spent by putting up their fees. I was merely suggesting that in certain professions and certain fields of their work that is probably not true. A certain amount of legal work is done on fixed scale.—*Dr. Walden:* A certain amount, but not one hundred per cent. of the work, or 90 per cent. of the work.

825. *Chairman:* Well, I think we have probably come to the end of this section at the present time. Many people are very dissatisfied with the present system. There are other suggestions as well as this one for improvement. I gather your main desire is to get rid of the great disparity between the allocation of expenses and expense allowances and actual expenditure.—*Dr. Cardew:* Yes.

826. And you would like to see some system which would do this?—Yes, the encouragement of better working of the family doctor and proper expenditure.

827. Your scheme is put forward not as being an ideal in itself so much as an approach to try and get rid of what you think is a bad scheme?—Yes.

828. *Sir Hugh Watson:* And of your three schemes the 1951 scheme is the one which you think has most to commend it?—If it could be applied I think it is the best one, yes.

829. In paragraph 50 you touch on the question of capital expenditure, and you suggest that the State should encourage the improvement of standards by making interest-free loans for the purchase of premises. That would cost quite a bit, would it not, at present interest rates?—Yes, it would.—*Dr. Hopkins:* But in return of course the public would derive a great deal of benefit.

830. Of course I know this is one step towards your goal of health centres staffed by doctors remunerated on a sessional basis. You are all building up to that, are you not, at the end of the day?—*Dr. Cardew:* I do not think altogether. I think we are accepting the fact that the only way you will get an improvement in general practice during the next few years is to introduce proper expenditure on the improvement of practice and premises, and we do not think with interest rates these days it is reasonable to expect a doctor launched from hospital into general practice without any assured income to have to find these large sums. The principle has been accepted for group practices already, and has not resulted in an overwhelming demand. *Dr. Hugh Faulkner* is on the committee that allocates these funds and I believe the demands are drying up.—*Dr. Faulkner:* Dropping rapidly. Surely in answer to *Sir Hugh Watson's* question, some people would say this is working away from health centres provided by local health authorities and was providing doctors with capital assets and interest in maintaining the status quo. I do not think one could say we have an axe to grind here. We are only concerned in encouraging better premises in general practice and widening the principle of the Group Practice Loan Committee.

831. *Chairman:* You refer to a much larger fund than £100,000. Did you deliberately not define that?—*Dr. Cardew:* We were in some difficulty here because when we originally proposed this fund for the encouragement of group practice—we have always been very much in favour of this—we thought a sum like £400,000 or £500,000 a year

would be absorbed by this need, whereas in fact £100,000 appears to be about meeting the need. We would hate to have to estimate on a much wider and more difficult field. I do not know what it might be, half a million perhaps, or it might be a million—a capital sum, that is; the only loss would be the loss of interest.

832. And that would not be, say, £1 million a year for ever and ever?—No.

833. Because presumably some time some would be able to repay it?—Yes. —*Dr. Walden*: In the present group scheme it is surprising, after the initial impact, how soon it becomes so much lower.

834. *Sir Hugh Watson*: In paragraph 51, *Dr. Cardew*, you do not expect any comforts from the Royal Commission on the question of mileage payments? That is under consideration elsewhere, and I think the Commission will probably agree to leave it there.

Differential morbidity we have dealt with.

That brings us to paragraph 53—recognition of experience. We have dealt with recognition of merit which you find very difficult. Now, recognition of experience, you suggest, might be dealt with by a special loading, by applying a special capitation rate to practitioners between the ages of 45 and 60.—*Dr. Cardew*: Yes.

835. Why do you suggest you should do that to gentlemen who simply have continued to live to that age when you are not able to assess merits?—Because we think that there comes a time in life—and it is not all that old, if I remember rightly, 45 to 60—when you want to slacken off a bit and are entitled to slacken off a bit and not work to the same pressure, without dropping your income. I think in most professions that is recognised. In partnerships it is recognised by the senior partner taking a larger share and doing less work. We are very much against this arbitrary division in partnerships and we think this could partly be corrected by allowing a special loading for length of service.—*Dr. Faulkner*: Also, most people grow more experienced and useful in general. A general practitioner of 60, we thought, was giving a greater service to the same number of persons

than a young man just appointed, perhaps 30, 32 or 34, which at the moment is not recognised at all. Some recognition was felt to be simply a mark of growing experience and responsibility.

836. *Mr McIntosh*: You stop at 60? —*Dr. Cardew*: We felt it was very necessary to stop at some point, because you do not want to subsidise old age, and I believe there are general practitioners on the list of over 90.—*Dr. Faulkner*: Ninety-four!—*Dr. Cardew*: And you certainly would not want to bribe them to stay on indefinitely.

837. *Chairman*: It does not sound as though they need much bribing.—*Dr. Hopkins*: But in any case the doctor with, say, a constant list would not have any increase in his income as he does get more experienced, and as he grows older, whereas in most professions I think it is true that there is an increase in remuneration over the years. But this does not occur in general practice except by increasing the numbers on the list.

838. Within a partnership I suppose it may happen to some extent.—Possibly.

839. Is that right?—*Dr. Cardew*: It does happen—indeed, Sir, sometimes to quite an unwarranted extent.

840. Well, assume for the moment that it is completely warranted. At what sort of age would you normally expect a partnership to stop going up as a proportion?—*Dr. Walden*: At 60 I think you would probably want to do a little less work. Is that what you mean?

841. No. You might start with a certain percentage of the partnership's income and rise eventually to a maximum percentage as you become pretty senior. Obviously there would not be a standardised age 30 or in the 40s.—I have brought the figures with me and would like to quote them to you at some time.—*Dr. Faulkner*: I would say in good practices parity tends to be reached quicker than used to be the case. The recent partnerships I have heard of have tended to three to five years; so I would say there are more practices on complete parity than there used to be.

842. At any rate you feel that general practitioners as a whole do not really increase their earnings very much now

after, say, the age of 40?—*Dr. Cardew*: No, they slowly drop.

843. You think that on the whole the profession would sooner see them, supposing they were getting the same amount of money throughout their working life, getting a little bit less earlier on and more later?—We sent a questionnaire out to doctors generally some time ago and we were surprised at the near unanimity that they would all like this length of service payment which would come later in their lives, even the young ones.

844. Was that questionnaire you sent out to your members on this basis of something coming between the ages of 45 and 60?—Yes, almost exactly that.—*Dr. Elliott*: I would like to remind you that this principle is carried out in the hospital service; there are increments between certain years.

845. I think the last of those increments stops before the age of about 40. I think 40 will be the last.—*Dr. Hopkins*: Then one-third of the consultants will be getting the merit award, which is another way of giving an increase to them.

846. *Sir Hugh Watson*: Partnership agreements: now, the first point you make there is that you reiterate your claim that compensation money should be made available to practitioners who are now no longer able to sell their practices. You made that point, as you say here, in the past frequently. The Treasury will not listen to it and you want to make it again.—*Dr. Cardew*: We feel that one of the reasons why the senior doctors in partnerships are often loath to part with the greater share of their practice is that, unlike the past, they do not get any reward for it at all. In the old days when you took in a junior partner you said: "I am going to part with some of my income but I at least get a capital sum paid into my account." Today you do not get that situation and there is less tendency to look kindly on a newcomer.

847. It would not be within your knowledge that most senior partners in any profession are unwilling to part?—I suppose that is so.

848. *Chairman*: And you have just said there is a tendency towards reaching parity more quickly on the whole.—*Dr. Faulkner* said in good practices.

849. *Mr. Watson*: Assuming that the Minister accepted the scheme, does the Minister have any authority in determining who the doctors should be? If the Minister is asked to pay this out of public funds does the Union envisage the Minister having any authority in the matter?—The sum is already voted by Parliament. It is sitting in a fund and it is just a question of when that amount of money is liberated. We now suggest a portion should be released to the individual rather earlier.

850. *Mr. Gunlake*: I do not think you make it clear in this paragraph whether you are thinking of an appropriate share of £66 million or whether that should be adjusted to allow for inflation. That £66 million was determined some years ago, was it not?—Indeed, yes.

851. You have said nothing on it.—No, because we could not conceive any circumstances in which Parliament would be willing to reopen the matter and grant a larger sum.

852. *Professor Jewkes*: You regard that as the normal form of robbery through inflation in which all Governments are engaged?—Yes.

853. Have you any comments to make on this rate of interest?—Yes, we never cease to bombard the Ministry of Health with resolutions annually on this matter, as I believe do other medical organisations.—*Dr. Walden*: It would be a real practical step if a senior partner were given some capital compensation from this sum of money, an inducement to take in a junior partner.—*Dr. Cardew*: It would not involve very much money as far as I can see. To start with it is usually the senior man who would be claiming it, and if he has a claim already allowed to him for £3,000 and wants to part with one-third of his practice to a junior man it would only mean £1,000 and probably giving it to him a few years before he is going to retire anyway. It would not involve a very large expenditure of money.

Chairman: I am just wondering how this comes into the question of remuneration of doctors.

854. *Sir Hugh Watson*: Now, Doctor, in the last two paragraphs of 54 you more or less suggest that there should be some control of partnership agreements. That is really what you are striving for?—Yes.

855. I doubt if that is a matter which is within the reference of this Commission, and I suppose it is a matter which ought to be taken up, if possible, by the medical associations.—We felt it was a matter for this Commission because the spread of incomes is definitely something which concerns the Commission. I believe in your letters to us the points you raised on the question of spread of income were some of the things to be considered. As two-thirds of the doctors are in partnership at the present moment it seemed to us very important that the spread of income should come under consideration.

856. But did you expect that the Commission should dictate the terms of partnership?—What we were hoping was that the Commission might take the view that if it laid down a spread of income for the medical profession for general practice it might well then say: "This can only be achieved if the partnership agreements do not distort these recommendations." I would admit that the Commission could not lay down the details of partnership.

857. *Chairman*: I think it is a fact that under the present arrangement loadings can be calculated in whatever way is most favourable to the partnership; is that not right?—Yes.

858. *Sir Hugh Watson*: Now, the question of assistantship, which is the next item. You deal with this in paragraph 55, 56 and 57, and you suggest in 56 three grounds on which a doctor could reasonably be entitled to employ an assistant. Would you agree that a doctor who is single-handed should be entitled to employ an assistant?—Only as a preliminary to partnership.

859. You contemplate that all assistantships should be temporary?—With the one exception we have made, the very rare exception of the odd individual who does not ever want to be a principal. I do not suppose there could be 100 in the country, but I think it is right to make that exception. I think there should be a limited period for which a man should be allowed to employ an assistant.

860. Are you telling the Commission that the number of people who turn out for one reason or another to be incapable of carrying on the practice of the profession is negligible; the number of people who qualify but subsequently find

they really are unable to carry out the duties of their profession for one reason or another—personality, health, or what-have-you?—It is left entirely to the judgment of the doctor himself to decide, but there are a very few people who decide right the way from the beginning that they do not want to take the responsibility of being a principal on the list and want for the whole of their lives to be assistants; there is a tiny number.—*Dr. Faulkner*: We certainly would not want to see permanent assistantship kept only for the reason that a very few are not capable of being principals in general practice. That would be most unfortunate.

861. One knows that in almost every profession there are persons who qualify, but who by their nature are not fitted to take the responsibility of carrying on on their own account.—We do not want to see such people in general practice as permanent assistants.

862. You would rather have them out altogether.—Yes.—*Dr. Hopkins*: There may be other reasons for persons not wanting to take on the responsibility, perhaps the young married woman with only a certain amount of time to spare would want to remain an assistant.—*Dr. Faulkner*: A part-time assistant.—*Dr. Hopkins*: A part-time assistant, yes. Therefore she would not want to become a principal.

863. *Mrs. Baxter*: And presumably the man who has a strong outside interest might come into this category.—Yes.—*Dr. Faulkner*: I think they are very small in number and do not need special legislation; they should just be allowed for.

864. *Sir Hugh Watson*: Apart from very special circumstances you look on assistants only as temporary and then only with a view to becoming partners?—*Dr. Cardew*: Yes.

865. *Chairman*: At the present time the single-handed practitioner who takes on an assistant can have an extra 2,000 on which therefore he will get the full capitation fee including expenses. Under your previous expenses system he would in future therefore only have two-thirds available from which to pay the assistant, plus such expenses as the assistant could legitimately claim.—He gets the full assistant salary.

866. Yes, but the practitioner will receive from the pool only two-thirds, only the net instead of the gross amount. He receives the gross at the moment.—That is correct, but presumably he will not have any extra expenses.

867. He will have some extra expenses.—Those would be allowable as in any normal claim. If he could show he needed two cars because he was employing an assistant presumably that would be allowed.

868. I think you might want to work this out, but I think it would be making it more difficult to employ an assistant.—At the present time a doctor who employs an assistant has to find the assistant's salary out of his gross remuneration, which means, say, £1,000 out of no extra payment.

869. *Sir Hugh Watson*: He gets tax relief.—Yes, but he has to find the money.

870. *Chairman*: £1,000 a year out of an extra gross which may be 2,000 capitation fees.—Yes, but then you are assuming that the doctor by taking on an assistant suddenly acquires an extra 2,000. In fact the next month, or three months later, he has the same number, or a few extra, and he actually has to pay the assistant out of the same remuneration.—*Dr. Walden*: This takes years and years, Sir.

871. I was really going by your paragraph 57 (c) which seemed to be assuming that.—*Dr. Cardew*: What I assume is that even if he has the full 5,500 he only actually receives £237 from the expenses pool on account of paying an assistant.

872. But you think that having the full 5,500, taking that very example, is rare and would take many years to achieve.—Yes, and in any case it would disappear in the future because he would not be allowed to employ the assistant for more than a limited period. I think a true analogy is that of a trainee general practitioner who receives his salary from the State; and in the case of a trainee the principal gets a small amount for training him. Of course he would not in this instance, but the analogy is very close and I think the application would be much the same.

873. *Professor Jewkes*: Have you any evidence of assistants remaining assistants for long periods?—Yes, very much evidence.

874. Is it of a statistical kind? I mean, could you show that assistants take much longer to get into practice on their own, or join partnerships, than used to be the case?—We would not like to imply in anything we say that it is normal for principals to abuse assistantships, but there are many instances we have met with over the years where young doctors who are desperate to get into practice have been offered assistantships with a view to partnership. They have installed themselves in a house and have started working there and at the end of the promised time when they were told they would be taken in, they are told for some reason or another that they cannot now be taken in. What are they to do at that stage? They could get out or they could hang on as assistants. They have often installed themselves and have their families with children at school, and it is a tremendous job to start again; so the result is they hang on. The principal may say: "Perhaps later. If the Royal Commission change their mind we might think of taking you in."

875. *Sir David Hughes Parry*: Have you further evidence that that general practitioner, when the assistant goes, takes up another one and carries on in the same way?—We have examples of eight or nine assistants in a row being taken on since the Act came in.

876. How do you suggest the Commission can deal with that sort of case?—Our proposal is that there should be a strict limit to the time during which the doctor is allowed an assistant, and it is to be hoped that this Committee would undoubtedly decide against allowing a doctor to employ an eighth assistant on the grounds that the doctor wanted to find a partner.

877. *Chairman*: Do you consider that assistants in fact assist, or do they really take full charge, as it were, of part of the list?—(*Dr. Faulkner*): Both really.—*Dr. Cardew*: There is a wide variation; there are practices where assistants do a large part of the work completely unsupervised, and there are other practices where they play a subsidiary role—there is a wide variation.

878. *Sir David Hughes Parry*: And do you think there are people who, by their mental makeup, would always be competent purely as an assistant, in a general sense, but never competent in the

full sense that a general practitioner needs to be?—There may be a small number, but in general practice you would not be likely to find very many. A person of that type would be more likely to go in for hospital work, where he never has final responsibility. It is not the same responsibility as that of the general practitioner who goes to the house and sees the patient and has to take full responsibility. In the hospital or the local authority clinic the doctor has nearly always somebody to refer to; and I do not think many of them will go into general practice.

879. So you do not think there is any point in setting up assistants as a class?—There are a very small number perhaps who would tend to be locums rather than temporary assistants. There are a number of people who are satisfactorily employed over, say, six months of the year as locums. Some of them want to write books or do other things, and—just by their own choice and not necessarily because of any character defect—they prefer to be locums and work very hard for a few months rather than assistants who are working hard all the time.

880. *Sir Hugh Watson*: On the question of the abuse of assistants, when you and I were young we expected to work hard and did not mind it; and I do not suppose that most young doctors would mind that today; they would not mind working as hard as their principals, or perhaps even harder; but in your view I gather there are a substantial number of cases where it goes further than that.—(*Dr. Cardew*): I think there is a very real difference there between the medical profession in the National Health Service and any other profession, because it is no longer a free market. In the other professions, and indeed in the medical profession before the Health Service, there was a very free and elastic market, and if you did not like your relationship you could go to another doctor and assess quite accurately whether you could get into the practice and how much it would cost you. But today no money can change hands and therefore the whip hand is bound to be with the man who sits in the saddle. The young man has little to offer except his skill. So it is all weighted one way and we consider there is a case for reconsideration and redressing the

balance. That is what we are attempting to do.

881. It could be that your suggestions go almost to the other extreme?—I do not think so. The General Medical Services Committee of the B.M.A. has already accepted the need for some form check up and got the regulations altered last year, so that a local committee can review the permission to employ an assistant at stated intervals, so already the need is recognised. We just want to make quite sure that this anomaly ceases, and that it is used for its proper purpose in relation to general practice.—(*Dr. Elliott*): Under the present regulations, a doctor does not automatically get an assistant. He has to apply to the Council, who can turn him down. The doctor has the right of appeal, of course; but there already exist, written into the Act, certain regulations regarding the assistants. And, as *Dr. Cardew* has said, there is a review taking place all over the country at the moment as regards doctors who already have assistants. In some cases the local medical committee have got the job, and we are proceeding with that.

882. *Professor Jewkes*: This is what I had in mind—whether the existing machinery was not satisfactory, because if there is this machinery which you have mentioned, why should not this have applied in the case of the general practitioner who has taken on eight and nine assistants?—(*Dr. Cardew*): First of all, it has only just come into operation, so it is rather difficult to see how it is going to work out; and the second thing is that it is very difficult to see whether the operation of this particular clause in the regulations can take into account anything at all except the duty of the practitioner to look after the patients on his list. The wording of the regulation is such that the Committee will not, I think, be able to enquire very much into the working of the practice or into the previous habits of the general practitioner in employing assistants, or anything else. I think it has a limited power, due to the particular wording of the Act.

883. In the case we have been discussing, where a general practitioner has had eight assistants one after the other, would not this fact have become known in the profession and would not that particular general practitioner have found

it difficult ever to get another assistant?—It certainly does become known, and I believe that the bodies that recommend young practitioners where to go are well aware of these facts, and they tell him about them. But of course there are a large number of young fellows coming out of the hospitals who are told, "There is a good opening here", and they go and see the man, and it is not until they get installed that this happens.—*Dr. Elliott*: I know of two doctors who have advertised for assistants, and when they advertise for an assistant they get 40 applicants—and they have hired 10 assistants since 1948.

884. There are too many assistants, is that the suggestion?—*Dr. Cardew*: There are too few openings in general practice.

885. Yes, but I thought you were proposing to set up machinery to make it more difficult for assistants to get into jobs?—No, Sir; what we are doing by our proposal, is positively bribing the principal to employ an assistant with a view to partnership. We are recommending that new money should be found for this purpose. We go to the principal and say, "If you employ an assistant you will get all the money back from the State for a limited period".

886. Cannot we look at it the other way, and say that under your arrangement the general practitioner, who formerly would have said, "I am prepared to take on an assistant as long as I do not feel compelled to think of him as a possible partner", he now says, "I am not going to take him on if I have to think of him as a prospective partner". Is that not going to decrease the number of openings?—We are not looking for openings as assistants, but as principals.

887. I thought you said there was a shortage of principals?—*Dr. Elliott*: No, it is the man who is having one assistant after another who causes all the difficulty for a young man trying to get himself on. For instance, there were only 97 vacancies in 1956, and we know that in southern England a fantastic number of people applied for the vacancies—as many as 100. Yet here is a practice and a practitioner who keeps on having one assistant after another and never takes these men into partnership.

888. But if he takes one of them into partnership then he ceases to be able to take on an assistant in the future. You see, if in fact there are too many assistants one can see abuse easily making its appearance. I was just wondering how far these difficulties went.—*Dr. Cardew*: It is difficult to answer that, because the people who apply for these jobs may be already in jobs as assistants, and perhaps they may dislike their present terms of service so that they put in an application for another job while they are already working. So I do not think one can assume that they are all floating around, as it were, without jobs.

889. *Mrs. Baxter*: The same man may apply for more than one job?—Yes.

Chairman: Are there any other points?

890. *Str Hugh Watson*: The only point I wanted to ask at the moment is about restricted entry into general practice. I think the Committee are aware of the difficulties of that, but I wondered whether you wanted to enlarge upon it?—I think that in our document we have said everything we feel we need, thank you.

891. One other thing I would like to ask: under 60 (a) you say, as regards the succession to a practice vacancy—"The argument in favour of maintaining the present system is the need where possible to maintain an established practice intact". Why is that?—It is not an argument that personally appeals to me very much, but many people have said that it is important to keep the doctor's practice intact—you have the house there and everything organised. It always seems to me to be an argument not having much substance to it, but it is one which is always put forward on this subject whenever it is debated. We see no purpose at all in maintaining a practice intact. There is a great deal to be said for letting the patients choose in a free market where they want to go, but we have mentioned this argument because it is one which is always quoted whenever the subject comes up.

892. Have you any suggestions for easing the difficulties of exchanging practices?—I have sat on a committee of the B.M.A. for three years on this, and we have done everything we can on it, but we have found nothing really satisfactory.

The proceedings were continued in camera.

FOURTH DAY

Friday, 17th January, 1958

SIR HARRY PILKINGTON (*Chairman*)

MRS. K. M. C. BAXTER

MR. A. D. BONHAM-CARTER, T.D.

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

PROFESSOR JOHN JEWKES, C.B.E.

SIR DAVID HUGHES PARRY, Q.C.

SIR HUGH WATSON, D.K.S.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

LORD MORAN OF MANTON, M.C., M.D., F.R.C.P., *called and examined*

893. *Chairman*: Lord Moran, we are very much obliged to you for coming earlier than had originally been intended in our series of hearings but there are many points, particularly the operation of merit awards, about which we would like to ask you and we will of course have to ask you, as we have said to other witnesses, many fairly searching questions because if we do not, there is nobody else to do so. I need scarcely say that this does not imply disbelief or hostility in any way, and any member of the Commission will in due course be asking you questions. I am afraid it seems rather a formidable collection to deal with one person but I am sure you are used to that.

Would you be kind enough to start, really for the purposes of the record since most of us know, by telling us briefly your special qualifications and interests in this matter from the beginning, and then outline the origin of the system of merit awards, its history and background and the methods of operation? I think I am right in saying you were a member of the Spens Consultant and Specialists Committee?—(*Lord Moran*): Yes.

894. And at that time you were President of the Royal College of Physicians?—From 1941 to 1950.

895. You are now Chairman of the Awards Committee?—Yes.

896. Would you like to tell us in your own words?—Do you want me to begin about Awards or about the other questions the Secretary was kind enough to tell me might be raised?

897. Take it as you wish because we shall deal with all these things in turn.—I think it would be best to get these

other things out of the way and then go on to the Awards—entirely as you wish.

The first question that the Secretary said might be raised was the total number of consultants envisaged by the Spens Report. In the actual Report of Spens there was no figure of consultants at all, nor did they really envisage any number for the future. The only figure appears in Appendix 2 which is 1,620 men plus 74 women. But that figure was obtained by Bradford Hill. It did not purport to be the actual number. It was really designed to bring out the range of payment over as many people as they could get hold of. They sent out questionnaires, and of those questionnaires sent out more than a quarter did not reply. They did not get replies from more than three quarters.

Secondly, they only addressed it to half or part-timers so that no whole-timers were included at all. As you know, this applied to 1938-1939 surveyed from a distance in 1947 and in the meanwhile a certain number practising in 1938 had died and were not included, and for various other reasons this number did not attempt to be any computation but there was an estimate at that time available, prepared for the BMA which is a totally different figure altogether. The only point I am making at the moment is that this figure of 1,620 only really applies to usable returns, that is returns to the questionnaire which could be used.

I will give you the first available figure. The first, what you might call official figure was on 31st December, 1949, and in succeeding Decembers to the present time the Ministry of Health has drawn up a number which it has

got in the first instance from the Grading Committees, and then later by adding to it the appointments as they were made by Appointments Boards. The first figure—perhaps you have these figures; do not let me take your time if you have.

898. We have it from 1951 actually.—The first figure—4,957 doctors and 232 dentists, giving a total of 5,189. That is for 31st December, 1949. Then in 1950 the number had gone up to 5,413 doctors and 236 dentists, giving 5,649. You have subsequent figures up to the present one, have you?

899. I would like to be certain it is the same figure.—1951—5,648 doctors, 237 dentists, 5,885 total.

900. That is not at all the same figure we have got.*—These are from the Ministry of Health. Then 1953—6,154 doctors, 252 dentists, 6,406 total. 1954—6,265 doctors, 248 dentists, 6,513 total. 1955—6,400 doctors, 250 dentists, total 6,650. 1956—6,490 doctors, 249 dentists, 6,739 total. 1957—6,604 doctors, 262 dentists, 6,866 total.

The only interesting figure I think I can add to that was that produced by the Evidence Committee—I do not know whether the Commission knows what the Evidence Committee was. It was set up in January, 1947, and it was a combination of two committees; the first was the Consultant Services Committee set up in September, 1943, of which I was the Chairman, and the Hospital and Services Sub-Committee of the Negotiating Committee, and those two were strengthened by the addition of people like the Public Health people and, I think, whole-timers, and it was representative of the whole profession I think. A great attempt was made to make it representative of all sections. That Evidence Committee set up in January, 1947, gave evidence to Spens and then in a supplementary memorandum dated 12th January, 1948, it said that by analysis it had estimated there were 4,279 doctors engaged in private practice, plus 553 municipal; but only 60 per cent. had replied, so they estimated that

roughly a thousand municipal people had to be added to the figure of 4,279 which, if it were accepted, would make 5,279 which is strikingly similar to the 5,189. In other words the Ministry of Health at the end of December, 1949, came to the same conclusions practically as a professional committee has done two years previously, at the end of 1947. I think that was all I want to say, in case there are any questions arising on numbers.

901. I think the difference in numbers is not as large as had been suggested by those who, I think, had simply worked on the figures in the original Report. Nevertheless it is much more striking in the case of doctors, for instance, than dentists. It is 30 per cent. Is that about what had been anticipated at that time?—You mean what was really anticipated? It is a long time ago and I am not at all certain about my facts, but my recollection of Spens is that we did not really concern ourselves with numbers, and particularly future numbers, except that there was an impression that the service would enlarge; and as the terms were that for every three new consultants there would be one Award, therefore it was anticipated this figure would go up as the service expanded.

Now as regards Merit Awards I ought perhaps to make it clear to the Commission that I am not really in a position to speak on dental matters because the Awards Committee has a sub-committee with Sir Horace Hamilton in the chair, with five or six dentists, and that issues every year a report to the main committee, so I am not conversant really with dental details in the way I am in the medical field.

Chairman: I think we would sooner confine ourselves to doctors, not dentists today. We may just ask a question or two about that point, but I think we will come to dentists when we meet more dentists.

902. *Sir Hugh Watson:* You have the Spens Report with you, Lord Moran?—Yes.

903. On page 22 there is an appendix. It brings out a total of 1,620. It was suggested to us by one body giving evidence that the Spens Committee's Reports with regard to consultants were based on the expectation of financial responsibility by the State which would

* The figures quoted by Lord Moran are in respect of England and Wales. Those quoted in Appendix A of the Health Departments' Factual Memorandum (Written Evidence Vol. I) are in respect of England, Wales and Scotland.)

accrue from 1,620 consultants, and if the Spens Committee had realised the number would have been much greater, they might not have made that report. What would you say about that figure?—That is so far from being true. The Spens were in possession of the figures I have just given you from the Evidence Committee. They never for a second took 1,620. They never dreamed of it. It was clear no whole-timer was included, and not only that, but a quarter did not answer.

904. *Professor Jewkes*: Just to get this point quite clear, Lord Moran; the only difficulty that arises here is that the Spens Committee in its reports used percentage figures. It recommended, for example, in the case of the A Awards that they should be four per cent. If they had made their recommendations in terms of numbers no misunderstanding could possibly have occurred, but I gather from what you say that when they used the four per cent. they had in mind a much larger number of consultants than Dr. Bradford Hill had collected information from.—As far as numbers go, I think the only actual statistical figure they had was this figure I referred to, by the Evidence Committee, and I do not remember that being stressed particularly at the time though it was in their possession and read to them.

905. In fact the Spens Committee had made its recommendations in terms of absolute numbers, they would probably have thought of four per cent. of the 5,000—they would probably have worked it out in that way?—Roughly the A Awards are 200 odd over the whole Kingdom. I think we had those figures at the time. In other words the percentages were an actual figure. I am certain of that. We have used them so often since, but I think it is roughly the 200 odd.

906. Of course it is a little off this particular question, but the new figure you have mentioned, the figure of something over 5,000 raises this other matter, that the statistics Dr. Bradford Hill collected, of the earnings of consultants, were definitely based on a 1,600 or 1,700 sample, and if it is true there were over 5,000 consultants, the sample was much smaller than anybody thought at the time.—That may be true. I have

not been into Bradford Hill's figures, but were they confined to the 1,600?

907. Yes.—Then what you say would be true.

908. *Chairman*: None of the whole-time consultants or specialists at that time were included?—No.

909. But were they thought in general terms to be earning about the same sort of incomes as those who were in private practice at that time?—It is difficult to answer that offhand. I suppose, generally speaking, the half-timer's income is probably greater than the whole-timer's, I do not know. I should think, generally speaking it is true.

910. I am meaning that the decision as to the remuneration of the 5,000 was based on the 1,600.—Yes. I thought the point you were really making was, was there any fallacy, that this was only doctors, part-timers as opposed to whole-timers. I suppose, as far as there was any fallacy it would be slightly against the doctors in that way, would it not? I am only guessing. It is not of any value, what I am saying; you would have to review all these various people, would you not?

911. *Sir David Hughes Parry*: The full timers' earnings were lower than the part-timers?—That is what I imagine.

912. *Chairman*: In that case surely to base the future on the earnings of part-timers, it was probably slightly in favour?—I should not think there is very much in it but I would have to have all the incomes.

913. *Professor Jewkes*: If I may just remind you, Lord Moran, of the Bradford Hill inquiry in the case of consultants: Dr. Bradford Hill, after getting his 1,600 replies, reached the conclusion which I am quoting:

"It is highly probable that the required income returns were obtained from slightly less than three-quarters of all consultants and specialists in practice in 1930 to 1939 and surviving to 1947. This is a high rate of return for such an inquiry."

If the 5,000 figure is anything like correct, it was not a high rate of return, unless we assume for some reason there was a big increase in consultants between 1938 and 1947.—At that time all these Grading Committees were going on and I have not the least idea what numbers

per annum they were turning out. This was based upon grading returns. How they were distributed all over the years I could not tell you.

914. *Chairman*: Can you tell me, Lord Moran, was there at that time a difference between consultants and specialists? —No. I think I should have said most consultants call themselves consultants but in the popular Press they are very often called specialists, but I do not think there is any value in that.

915. The Report was the Report of the Departmental Committee on the Remuneration of Consultants and Specialists, but there was no difference? —No. I suppose it is conceivable that some old fashioned people might say that in some of the minor specialties they might be called specialists, but there exists in my mind no differentiation.

916. *Professor Jewkes*: Is it possible that quite a number of people who after 1948 were graded as consultants would not have been so regarded in 1938? I am looking for some explanation for the increase in the number of consultants. —I think the explanation was, if you go back, and that is what I take it you are doing, say five years before that, the distribution of consultants throughout the country was extraordinary. It was accumulated in big cities; places like Shrewsbury and that sort of place would have practically none. Speaking of Barrow-in-Furness where I once lived, in my time there was not a single consultant there at all, nor in my time—my father being a doctor there—do I ever remember a consultant coming in, except for one occasion for a spinal tumour. So you will see one of the chief objects of the Health Act was to spread the consultants so that they should be available not only to great cities but all over the country. Therefore what you say must be true. There was a tremendous leeway to make up. When the Health Act came in and they took over hospitals, they took over perhaps people who would not have been previously considered consultants. Is that the answer?

Professor Jewkes: Yes, thank you.

917. *Chairman*: Would you like to pass on?—The second point is the historical origin of the Merit Awards system. There were two purposes for which this system was set up. The first

was because it was felt, if medicine was to compete for recruits with other professions, what they called a significant minority should be able to aspire to incomes more or less comparable with other professions. In that connection the Bradford Hill figures were used and they brought out these facts; that 11 per cent. of the incomes investigated did not exceed £1,000 per annum, that 13 per cent. did not exceed £5,000, 17·9 per cent. of surgeons and 17·1 per cent. of gynaecologists had incomes greater than £5,000, 29·5 per cent. of surgeons and 27·6 per cent. of gynaecologists had incomes greater than £4,000. I think the sole object of that was to prove that a very appreciable minority of the consultants for that time had very large incomes.

Spens thought that some reduction in these was justifiable on the grounds that in a service the men would have financial security which they had not had in the past, and that I think was absolutely true. There was none of the risk of private practice. They had much more security and so they made this reduction. At the end they said, as I have said, a significant minority must have the opportunity to earn incomes comparable with the highest which can be got in other professions, and they arrived fairly arbitrarily at the figure of £5,000. The net result of all that was their conclusion that differentiation dependent upon professional distinction was essential to any satisfactory method of remuneration. So all I am saying under the first heading was that they felt, to compete with other professions, there must be a significant minority able to earn something like the same thing.

They dealt, as you know, with age. I need not go into that, need I? The increments, the Commission knows, were arranged so that if a man became a consultant at 32, he went on increments till he was 40, but beyond that nothing was added to his income except the Awards. That, I think, is already familiar to the Commission.

The second heading was to provide an incentive. There were therefore two things in the minds of the Spens Committee primarily in granting these Awards. One was that a significant minority should be able to compete, with other professions for the best recruits, and the second was that there should

be an incentive provided. What is interesting, I think, looking back on it, is that both those suggestions did not come from the Spens Committee in the first instance, but came from the Evidence Committee, that is to say they came from the body of the profession and not from an isolated committee. Firstly, those figures I quoted are taken from all incomes and the Evidence Committee came to the conclusion Spens adopted, that they must have that to compete. Secondly—what I am going to say originated with the Evidence Committee—their memorandum said that length of service should not be the only factor in determining rising remuneration. They said it was essential to maintain an incentive. This was taken up by Spens and I remember very well that the lay people on the Spens Committee, who were in a majority, were attracted by this incentive. They thought it might apply to things outside medicine and they thought, at a time when medicine was passing over from a highly competitive individual profession where the rewards were really according to individual effort, into a service, there might be a considerable slackening of effort. That was the feeling, and they thought this incentive might do something to meet that. The Spens Report said that there should be some way of picking out really eminent specialists for extra remuneration.

Opinions as to how this should be done at that time varied. For instance the Evidence Committee envisaged that it might be done by the Appointments Committees attached to regions; but the Spens Committee saw that would not work, and for the first time suggested it should be done by a body for the whole country, or some outstanding body sponsored by the Royal Colleges. So all I am really trying to say up to date is that as far as the historical origin is concerned there are two things which really activated us, and one was this question of recruiting and the other the question of incentive, and that both really came from the profession itself, from the great body of the profession as represented by this Evidence Committee. I do not think I want to add to that unless any member of the Commission would like to ask questions.

Chairman: I do not think I have anything to ask on the history, Lord Moran.

Many of the points you made will no doubt come up for discussion later.

918. *Sir David Hughes Parry:* I thought there was a hint in what you said, that this method of payment was put forward, in the first instance at least, as a transitional method from a competitive profession into a more secure profession?—If I said that I certainly did not mean to convey that impression. There was no thought like that in Spens. What was in Spens' mind was a strong argument for using Merit Awards as opposed to some other incentive arrangements, not any question of transition at all—that was not in their heads.

919. I thought you said it seemed that the profession was to be converted from a highly competitive one to a more secure one.—Yes, but I only said that because that was what was in their mind when they were so enthusiastic about incentive. But they did not think this was going to pass over in a period of five years. They wanted an incentive to keep men going. It will always be necessary, as we know, in the combatant services. I do not know how many committees I have sat on in the last years connected with the combatant services, where the simple question is, how can we keep these people on their toes, these people being the members of the Royal Army Medical Corps and so on, and this was always the same; it was not a question of pay but of getting sufficient professional opportunities, and we always were defeated and never did find a solution.

920. *Chairman:* When you say, in the mind of Spens, you mean the Spens Committee?—Yes, I do.

921. Of which Sir Will Spens was Chairman?—Yes.

922. But nearly all the Committee were in fact members of the Royal Colleges? There was a considerable medical body?—We were in a minority.

923. Five, I think?—I think so. I do not remember exactly. It was quite striking to a doctor on that Committee, that up to the appearance of the Awards the lay people were, I would say, very critical of a great deal of our suggestions. In fact we had the impression they were not extremely favourable, but on the production of Awards, which came from the

Chair, the whole thing altered. They were really in favour of the Awards from the first.

As far as I know, and I may be wrong in this, the only alternative suggestion that ever came before any committee that I can remember was not then called responsibility, but I think was called establishment, if I remember rightly. That is to say, it was associated with the heads of the hospital and that sort of thing. It is very much the same as responsibility, but this is a new word comparatively. Both the Evidence Committee and the Spens Committee did discuss alternatives to this measure but they never looked with favour on them and I think the sort of arguments as far as I can reproduce them were something like this. If you talk of responsibility payment, I think the first thing you say is, what do you mean by a post of responsibility? As I know it, when I was an Assistant Physician at St. Mary's, my responsibilities were the same as at any subsequent period of one's career because, although it is true one had not anything like the same number of beds, one had out-patients, which I need not say to any doctor, is much more difficult. You get a stream of people coming with very few physical signs and it is a test, whereas if you have the case in bed you can take your time and there are physical signs and it is an easier line of country, so I would not say from my experience—and I think everybody would agree—that you can really differentiate responsibility in the hospital. In other words I would say that "responsibility" means the same as seniority in practice.

I tried to find exceptions to that. First of all I went through medicine and surgery—clearly the senior surgeon and senior physician. Who would get it in the eye department—again I can only think, the senior eye man with perhaps three men on the staff working there, the same with the ear, nose and throat department, and so it went on. Then I came to the radiology and pathology departments. There I think it is conceivable you might make an exception because you might say the head of such a department in the ordinary course of things would be selected by election. They would not necessarily take the second in command—they might, but not necessarily. But even if that were an exception, if you had responsibility pay-

ments it simply means that automatically such posts would get them whereas now, under the Awards system, the man who is head of a laboratory, radiology or pathology, is always considered very carefully and if he is rejected it is because the evidence is against him. In other words, in these two exceptions, if you had responsibility payments it would be automatic whereas under the present system it is not automatic.

One of our most painful jobs has been passing over senior physicians who had been put on years and years ago and do not really make the grade and therefore I suppose another thing that might occur to the Commission would be the question of the Medical Superintendent who, I suppose, under such a system would come up for consideration. I remember going down to a region in the West Country and the regional people made certain recommendations and we did not accept them and they were very hurt about this, and I went down to interview them to try to explain matters. I said that what I really wanted to know was how this man differed from the hundreds and hundreds of medical superintendents all over the country in mental hospitals, tuberculosis sanatoria and so on; and they said—"we had not looked on it in that way, he does not differ in any way." You could not possibly give responsibility payments to all Medical Superintendents. Some drop into a routine; some are very good. It is obvious the whole object of the Awards Committee, so far as that branch is concerned, is to pick out the people doing a little more than their neighbours, and not just ticking over. The last case where I think you could make an exception would be the professors of medicine and surgery. Under the Award system the same thing happens—they are so outstanding. I think if you looked through the Professors, all teaching medicine and surgery in hospitals, they have very high Awards now, so reviewing what I have said, I do not honestly see how a case can be made out for responsibility payments.

At the various hospitals in London you are either retired at 60 or 65, presumably because your powers are waning—that is the assumption anyway. A senior surgeon would be rewarded in

this way just at the time that the guillotine was closing down on him because of inefficiency due to age. It seems to me an anomalous thing. I do not know at what average age a man becomes a senior surgeon but generally speaking it is quite late on and he would therefore be receiving a responsibility payment at a time when he was looking forward to retiring from the staff because of age. It does not seem to me, looking at responsibility payments, just as an argument, that a case can be made out for them, because I think it is really synonymous with seniority.

Finally—what is the history of this suggestion? As far as I know, and I may be wrong in this, it has only been brought forward by the British Medical Association. I do not think I know of responsibility payments being suggested, officially at any rate, anywhere else. The history was this: at what is called the representative meeting of the British Medical Association in 1956—that is, the annual meeting—the following resolution was proposed by Mr. Dunbar, Glasgow:

"It was resolved that in the opinion of this meeting . . ."

A representative meeting is a tremendous meeting of I do not know how many people, a sort of Albert Hall performance.

"... the Council should consider the desirability of abolishing the Merit Awards Scheme for members of hospital staffs, unless in very exceptional cases, and of replacing it by a system allowing for responsibility payments."

I was rather concerned naturally when I saw this, but I was reassured when the British Medical Association told me this was passed with hardly any discussion, and at a meeting nearly all general practitioners, who were unfamiliar with the details. The subsequent history of it, I think, bears that out. I was asked by the Consultants Committee of the B.M.A., of which I have not the numbers—I suppose it is 50 to 60, perhaps more, and it represents all their consultants. I was asked by them to address them on this question of Merit Awards, and at the end when I had left they passed unanimously in favour of it, and the Council recorded this:

"That Lord Moran, Chairman of the Awards Committee, attended a

meeting of the Central Consultants and Specialists Committee and explained the method of selecting consultants for Awards and the steps taken to ensure their equitable distribution throughout the country and in various specialties. The Committee has affirmed its confidence in Lord Moran and his Advisory Committee."

and that is unanimous. I talked to them for about, I think, half-an-hour or forty minutes and they then asked very searching questions for a long time. Then I left and they had their vote. The Council of the British Medical Association then considered the resolution after that had been done, and passed this:

"The Council does not consider it desirable, however, to take any action which would result in the abolition of Distinction Awards."

and at the annual meeting of the B.M.A., July, 1957, a year after, Mr. Sellors moved the approval of the Council's resolution, and that was carried. I have gone through that rigmarole rather to show that in this body they have apparently abandoned the responsibilities scheme quite definitely.

924. *Sir Hugh Watson*: You are familiar, Lord Moran, with the fact that in the teaching profession a person is given responsibility pay when he is the head of the department, or headmaster of a school. I gather from what you say, in your view there is no comparison between that sort of responsibility and the sort of responsibility which is here under discussion.—Would it not be fairer to say they work in different ways? I do not see how we can work ours. I believe, if you asked anybody who comes before you, how you would work responsibility payment, I think he would be flummoxed.

925. *Sir David Hughes Parry*: May I suggest there might be in certain instances a combination of both methods; for example in some specialties where there is headship of a department that might be regarded as a personal responsibility and in that case that might be rewarded rather in that way than by Merit Award?—Is not the answer to that, if I am right in what I have said about the exceptions, that this would only apply really to two departments and that they do now receive Awards unless the evidence is against them?

There is no pathologist who is head of a department in a teaching hospital who is not very carefully considered and the same applies to radiology, and if it is an important non-teaching hospital the same is true. Really, if you had a dual system, you would ask two things; what do you gain and what do you lose? Immediately you begin to dilute it you are losing initiative. The man will go up senior without any effort on his own part. He will compete for this headship of the radiology and pathology department whether there is any inducement or not. It is absolutely essential, he must do so for his career.

926. You are describing an incentive as a purely economic incentive.—I think, in a Committee like this, it is pure waste of time to talk about vocation because we are concerned with what I call the hard facts, and I personally think that a man who is worth his salt—for instance, if you ask me the highest expression of medical practice at the present time, I should say a professor of medicine such as Pickering, the Regius Professor at the present time at Oxford. But I do not think you gain by enlarging on it. People who believe in vocation, I am sure, are people who do not talk about it. When I hear people talking about it I always get very suspicious.

927. *Chairman*: Now could you tell us a little about the scheme as it works, as it is administered, and perhaps deal with some of the things you must know cause anxiety amongst many doctors.—It is a little difficult to know exactly where to begin here but I think the only way really is to attempt to take you round the country. I will try to make it as brief as I can. If you find you want it in a different way I wish you would say so.

928. Could you tell us as a start exactly who administers the scheme and how that body is appointed?—The Committee of fifteen administer this scheme and they are appointed by the government on the advice of the Royal Colleges.

929. Do the Royal Colleges nominate the precise number or not?—The Committee is composed really in this way: there are three physicians, three surgeons and two gynaecologists but it is always understood and in practice

works, that one of the surgeons or physicians is in a special department—Dr. Ingram at the present time represents dermatology, for example, but the three Royal Colleges are responsible for these eight people. Then a representative of the Vice-Chancellor's—I presume, appointed by them—he comes to us, and then a representative from the Medical Research Council. That is ten. There are three Scotsmen appointed by their bodies—that is thirteen. I am an extra as Chairman—that is fourteen.

930. *Professor Jewkes*: And a representative of the B.M.A.?—No. I asked Dr. Hill, who was then Secretary of the B.M.A., whether he would like to take part in this Awards system, and his reply was that the organisation of the B.M.A. was not adapted to it.

931. *Chairman*: I think actually on page 18 of the Ministry's memorandum it says fourteen.—Perhaps if you turn to the Report of the Ministry of Health you will find, I think, there are fifteen. I have left out Sir Horace Hamilton who is the only laymen on it and he was a Treasury civil servant in the past, he was Permanent Secretary for Scotland, and he is the only layman.

932. If I may come back to the eight members from the Colleges, do the Colleges say these are our eight people and the government accept it without discussion, or do the Colleges say here are twenty-four people of which you are under obligation to select eight?—The government have the final power, but I do not think, speaking from memory, they have turned down any suggestion. It is the exact number.

933. They are in fact nominations of these various bodies?—Yes, that is true.

934. You say there are one or two specialties that it is particularly understood will be covered?—Yes, perhaps I could explain. Dr. Aitken represents the Vice-Chancellors at the present time. He is Vice-Chancellor, Birmingham. Sir Horace Hamilton is the layman. Of the three Presidents of the Colleges: Sir Russell Brain, Professor Claye and Sir Harry Platt, at that time—he is no longer President but has been succeeded by his successor. Then Professor Dunlop, Mr. Galbraith and Mr. Graham represent Scotland. Dr. Ingram represents dermatology, Dr. McNair and Professor

Claye represents obstetrics; Professor Pickering at that time represented the Medical Research Council—he has been succeeded by Professor McMichael. Dr. Sheldon of Wolverhampton is a non-teacher and he is a physician. Professor Windeyer represents radio-therapy, so at the present time they are the two specialties represented.

935. May I take it all the medical members of this Committee are of such outstanding merit, that to the profession and everybody it might be assumed they might be among the Award people, if they were still eligible on it?—I think it would be fair to say, they are all A's.

936. They cannot have receipt of the Award after a certain age, I believe.—That is not absolutely accurate.

937. *Sir David Hughes Parry*: They are appointed by the Ministry for what period? Is there a term for them to serve?—Yes. There are fifteen members and there were fourteen till just lately and there has been thirty altogether since it started in 1949. They are appointed for three years on what I think the Civil Service then called the rotational system; a group for a year, another for two years, another for three years. It is apparently the way they always do it, so a man suddenly disappears—I never know why.

938. *Chairman*: The President of the Royal College of Surgeons. I gather, had disappeared and been replaced simultaneously with the ending of his Presidency?—*Sir Harry Platt*. He might have gone on there; but we regard it as desirable the President should be on, and I have always asked their Colleges if possible to send him on.

939. So the President, as President, is permanent?—Only by my request, not by the government.

940. You have been Chairman of this Committee since the beginning?—Yes.

941. Are you also appointed for three years?—No, I do not know exactly how I stand but it is certainly not a three year thing. I think I can be dismissed arbitrarily at any time. In other words, these people are on for three years, but I do not think I have any period.

942. You do not come up for reconsideration?—No.

943. Do the Committee meet often as a Committee fully attended and do they

go round the country?—The Committee meetings have varied; in the first year they met, I think, 18 times because it was absolutely new. Now they really only meet officially as it were on the two days when they are drawing up their report, but that does not really give you the picture of what they are doing. They do not all go round the country; that is to say, Doctor Sheldon is always present at the Midlands, Sir Harry at Manchester, Ingram at Leeds, but 14 people do not go around. That is left to Sir Horace Hamilton and myself. You really want to know how the thing is done, do you not?

944. Yes.—I ought to explain to the Commission how vacancies occur. They occur for three reasons: one because a man dies, secondly because he retires under an age limit, and thirdly—this is the most prolific source in the past—because for every three new consultants there is one new Award, so from those three sources you get your vacancies each year. I have excluded the first year as being abnormal because there were so many, but for the subsequent seven years vacancies averaged 238. That is to say, 21 A's, 72 B's and 145 C's.

945. When you say a vacancy, Lord Moran, and give those three reasons, a vacancy never occurs because somebody you once thought outstanding turns out to be not so outstanding after all?—No. I confess I have undertaken some hazardous experiences in my time, but not that one. The fallacies are so enormous. Suppose you decided, not from his conduct or anything like that, but a man's work had deteriorated, you find some reason or some source of worry or health which you had not known about, and I think it is quite impracticable to have a sort of thing where a man is turned out on the grounds that his work had suffered. I do not think it is a practical proposition, there are too many fallacies.

946. Once you are there you are on the list?—That is true. The 238 vacancies for the whole Kingdom—that figure is always provided for me by the Ministry. We have nothing to do with it. We then divide that into half for the provinces and half for London. That is largely in proportion to the number of consultants. There is a slight disparity. The number of consultants in London

and the provinces is in the three thousands, but there is a slight disparity, but that was held to be offset at the beginning and has not been altered since, because there are twelve London medical schools with very large staffs, whereas in the provinces there are ten, of which you have Oxford and Cambridge, and you would not compare them with Birmingham or Manchester, because they have not the numbers. So we start really with 119 for the provinces. There are ten regions and we divide those 119. This has to be done according to the number of consultants in each region. The number of consultants in Oxford and Cambridge regions are nothing like the same as Birmingham and Manchester. It is done for us by the Ministry.

947. The Ministry provides the number of those in the provinces as a whole?—What I really ask the Ministry for is the 238 figure, and then halve that, and say to the Ministry—will you work out how much goes to Manchester and how much to Cambridge, according to the number of consultants.

948. So there is a total, and in any one region in the provinces Merit Awards ought to be very nearly the same?—Yes, I will give you exact figures in a moment if you like. You find that you have a much bigger region in Manchester and Birmingham, therefore you will find there is a smaller figure in Cambridge, though not very striking. Probably you would like those figures for the various regions.

949. *Sir David Hughes Parry*: To clear one point about Oxford and Cambridge Schools of Medicine, they have not such a large number because they are not large clinical schools?—Yes, there is nothing comparable.

950. They are really pre-clinical schools?—That is it.

951. *Chairman*: I do not know that we know those figures at the moment but we have some figures in front of us which I think you know, Lord Moran, which do not entirely bear that out. The percentage in each region is not identical?—No, that is why I offered just now to read them to you. You will find, if you take the figures, they are all in the thirties. If you find Oxford is

the highest, that is because of the number of Nuffield Professors with very big departments and so Oxford is always top proportionately.

952. There is one region that actually is about 27·7.—If you got that for a recent year, you would find it vary for other years. The answer to your question is that merit is the deciding factor, and we are breaking away from merit when we are dividing up into regions. It cannot be done any other way, you see.

953. That was what I was trying to find out. What is done, Lord Moran, is that you take a half, which is 119, and then it is allocated among the regions?—Yes. I see exactly your point. Can I make it clear this way? Because it is impossible to compare with Leeds and Newcastle, you have to divide it up in this way, but when we have the Ministry figure for the regions, when it comes in, if we cannot get the people with the merit required just for the moment, we go to the others, so the regions are never quite equal mathematically as sent by the Ministry; but if you take it over a period of eight years I do not think you find any unfairness between regions. The figure you quoted—27 or 28 per cent.—when the Ministry remind me of that fact, we try if we can to bring that more into line. In other words, we watch those figures.

954. But in fact, Lord Moran, that particular one—28 and a bit in 1955, and 27 and a bit next year—just as a percentage that particular one seems to have rather decreased.—I would not be at all surprised. That might be so. It does not affect the principle; we do try to keep them equal as far as we can, but merit is the deciding factor and this is a compromise between a geographical distribution which is simply on numbers, and a distribution which is on merit, and we cannot take it any further than that.

955. Perhaps you will go on and explain how, having allocated as it were to each region a certain number as now, how does that help?—Supposing you take 119, and just for the moment supposing we assume that we have to divide it up, a compromise between merit and the other, it really comes to this: we go to a region like Newcastle with one A and four B's, and seven C's. That is a hard fact. If you multiply that you find it makes up the number, so we go down to a region knowing we have to get

one A four B's and seven C's. That varies to a certain extent. For instance this year, which was a small year, the figures were: Manchester—1 A, 2 B's, 5 C's; Liverpool—2 B's, 4 C's; Sheffield—1 A, 2 B's, 4 C's; Leeds—1 B, 4 C's; Newcastle—1 A, 2 B's, 4 C's; Birmingham—1 A, 2 B's, 6 C's; Bristol—1 A, 2 B's, 4 C's; Wales—2 B's, 3 C's; Oxford—1 B, 2 C's; East Anglia—1 B, 2 C's. That figure is divided by the Ministry and you will see—I do not know which region your 27 was.

956. *Liverpool*.—In this point, Liverpool is unique in having practically no region, if you consider Liverpool and knock out Chester and Wrexham. Compare that for a moment with Leeds; you have got the whole of Bradford, Halifax, Huddersfield, an enormous number in the region—and so you have got really no district. I do not think you will ever bring that particular region up to the number for that reason, because it is almost entirely a teaching hospital one. In other words I have not the slightest hesitation in saying, as you have quoted Liverpool, that is a correct figure because it cannot compete with places like Manchester and Birmingham with their regions.

957. *Sir Hugh Watson*: A small question for the record; what about Scotland?—I think we were worried about that. When it came out originally they were under our Committee and I said there ought to be a permanent Scots Committee and that it ought to be really self-governing, because I said that if we began dabbling in the Outer Hebrides we are going to be sunk. In effect what happens is that Committee is self-governing and reports to us every year, and the three Scots representatives move its recommendations—it has never been turned down. They do their Awards differently. They do it all from a central base. They do not do it by going round the country.

958. They are not included in the 238?—No, this is England, and Wales. There are no Scots figures here.

959. *Chairman*: These figures as to the geographical spread, are they made known? I am not clear about that.—I should think the answer is probably, no.

960. But it is known broadly that there is an attempt to get a spread?—Yes.

961. This kind of information is what, roughly, you would have given to that

meeting which you described as the Central Consultants Committee, of the British Medical Association.—Do you mean they were not told these details?

962. No. I meant that this is roughly what you did tell them.—I spoke without notes so I have no idea really, but I think it is. There is not any mystery about this regional business. As I say, it is the only compromise we come to. We try and keep level. We would like if we could to keep all the figures for all the regions level but it is not practicable. This is the nearest we can get to it and now, in the case you have quoted, I do not think we shall ever get Liverpool alongside Manchester simply because of the size of the district, otherwise I should have thought, generally speaking, it would be possible to do it.

963. *Professor Jewkes*: Could I just ask that in searching for a uniform geographical distribution you would never attempt to impose that principle so rigidly that you had to put on one side the merit criteria?—No.

964. *Chairman*: Is one of the reasons for taking geographical distribution at all in order to make quite sure that consultants have an incentive to be in any part of the country?—I think Spens put it in these words:—"To disperse these awards over the whole country"—I think they used words something like that.

965. I was trying to get at the reasons.—The reason they did it was this—I am not at all certain whether at this stage it would not be well to read to the Committee because it is very relevant to what you are speaking about now. We regard this dispersal of the awards over the country as probably the most important single thing because we want, as it were, to upgrade the hospitals to one class, not to several classes. It was put to me when I was President and the Ministry asked me for advice. Should a surgeon at Guy's be paid the same as a surgeon at a hospital in Barrow-in-Furness? and I said, yes, because you cannot get a uniform service unless you do that, but there was some opposition. If you are going to pay different sums the men are going to congregate in big centres and, therefore, it is very important.

In this connection I have a letter which came to me this morning from Dr. Sheldon who is a very well-known figure

in the Midlands. He gave me permission to read this letter to you when I asked him:—

"I see that you are to give evidence before the Royal Commission, and having read what was said by Sir Russell Brain and others in this week's British Medical Journal there is one further point which I think should be stressed about the value of the merit awards to the service.

Under the merit awards system a young and able consultant can go to a non-university provincial town in the certain knowledge that in that same town he can rise to the maximum salary available in the service. By this process a provincial town receives an enormous benefit by its ability to attract the services of the best consultants. I do not think it is sufficiently appreciated in a large city like London what an immense amount of comfort is derived in a provincial town from the knowledge that its citizens can trust its consultants—who, in the course of time, tend to become household names. Any system which would have the effect of taking men out of one town into another in order to obtain the salary they deserve would be very bad for the town and would be grossly unfair. Why should the residents of one town, knowing that they can never have more than say an average E.N.T. surgeon, nevertheless subscribe through their taxes to a state of affairs in which by virtue of their larger size other towns may always be enabled to have a first-class one?"

The writer of that letter is a greatly respected figure in medicine. He is a non-teacher and this is testimony from a non-teacher.

I think it would be absolutely disastrous if we interfered in any way in this system for getting a spread of consultants. I know how badly it stood before the Health Act. Nearly all the big university centres were the places which got them but the spread has been quite extraordinary since.

966. I think Spens put it quite clearly when they said:—

"... they should not be allowed to gravitate towards a few large teaching hospital centres; and we wish to stress that in making awards as between

those who on other grounds appear to have equal claims regard should be had to the desirability of spreading such awards over the country as well as over different branches of specialist practice".

—Yes.

967. *Mr. Bonham-Carter*: Is it true to say that within the profession men do not move much during their careers, geographically?—You are talking only of consultants, are you not?

968. Yes, I am talking of consultants. —Yes, I think it would be true that if a man gets on to a hospital he is fixed for life—if it is a big hospital. I think that is true.

969. Therefore, it is not significant to the extent that it would interfere with the figures over the years?—It has this effect; supposing you are a first-class man at Guy's, and supposing you do not get on at Guy's, which might easily happen because of the timing of the vacancy, well then you have every inducement to go to one of these remote places because you can get the maximum salary there. Therefore, you will only ask yourself, will you get the kind of work you want, will the material be good enough?

970. There is not enough of it in the course of years to upset the regional distribution? You see, a man could get an award in one region and then move to another, could he not?—Yes, he does, but not very often. He does carry his award with him certainly.

971. Normally, do you find that you fill all the vacancies each year?—We try to, yes.

972. *Chairman*: There is one point I have not got quite clear. I think you said that there are about the same number of consultants in London and in the provinces in England and Wales as a whole?—Yes.

973. But there were rather more in the big teaching hospitals in London than in the provinces and that a split, therefore, I gather, of giving half the awards to the provinces and half to London was in a sense slightly unfair for London, or have I got it the wrong way round?—I think the figure in the provinces is slightly higher than London—it is a matter of hundreds.

974. The total number in the provinces, yes, I see. It is quite appreciably high.—Yes. I confess that before this Commission was set up I had not gone in detail through the figures. When we got the figures I then looked at it and there were a great many other factors which I went into, the density, and so on, of hospitals. Whether there is a slight disparity, I do not know, but it is not very great.

975. But there was rather a higher proportion that might come to London.—I think it might very well be so.

976. But that at the moment is not being redressed at all?—No, it has not been put right. In fact, I did not know about it until a week ago when I saw the figures and I was rather surprised.

977. It might be worth considering.—Yes.

978. *Sir David Hughes Parry*: I want to be quite clear that merit is the ultimate criterion of the award?—Yes.

979. Not the geographical distribution?—Absolutely true, yes.

980. You were talking earlier about the difficulty of defining the post of special responsibility, it is equally difficult to define merit in this context, is it not?—I am often asked that question and I will give you a direct answer because I think it is a very simple one. If you are a doctor and there is someone either in the eye department, the gynaecology department or the surgical department, or any other, if you are on the staff of the hospital, you will not have the slightest doubt who you will want to call in for you and your family. There is not the slightest hesitation. I have not seen any man hesitate when his family is ill. You say: "Who do you want?" He does not turn round and say: "There are three names", he says: "I want so-and-so", and that is precisely what we want in the awards. It is not a mystery but the fundamental thing about this is that we feel we must pick the right kind of people to advise us. I do not have views at all as to whether X is better than Y. I sit on the bench and collect the evidence for the committee, and that is the whole business of it, and we must pick the right people to advise it. It is a rare gift this picking of people, as everybody knows, and by trial and error we have the people

we want, but there is still room for improvement. That will always go on.

981. *Chairman*: Would you mind getting on to that part next and having in your mind, if you like, any one region, a region that is going to get, if merit justifies it, say, a total of 20 awards.—It comes to 12—1, 4 and 7.

982. Twelve awards during this next year. How would you go about it in the districts, in the regions?—I would have to divide them up first of all into London and the provinces and then into teaching hospital and non-teaching hospital. We keep them apart because at the beginning of this award system the feeling was such that one of them said at the first meeting we had, that these awards were designed for Guy's and St. Bartholomew's. That was a way of putting it that they did not think they would ever go outside London and certainly would never go to the smaller hospitals. It has been our main object on the committee to prove that that is not so and in fact the main object in travelling round is to disseminate these awards in the hospitals. We could really do it all, if it was teaching hospitals, without travelling.

What we do is go to, say, Newcastle, and there we need one A, four B's and seven C's. There is not any difficulty about the A. Whether he is at the teaching hospital or whether he is in the region he will be so outstanding that at the very most there will not be more than two or three candidates and very rarely that number. Nearly always when you go—as I will tell you in a moment we have separate interviews with people—when you ask who should be the A, you will not get any difference, it is more or less known. That is very far from true of the C's but it is true of the A's. Then we come to the four B's. What we do is we go to the teaching hospital and we have two methods of investigation. One; we have separate interviews of about half an hour each with six, seven or eight people, or some number of that kind varying in different regions, members of the staff, members chosen by ourselves, not by them, and always chosen really by trial and error because we have found they deliver the goods—they tell us names which prove ultimately to be sound.

983. And the "we" you are referring to at this time is who?—Sir Horace

Hamilton and myself, with Dr. Ingram in Leeds and Dr. Sheldon in the Midlands, as I explained earlier. Perhaps it would help if I handed to you copies of what I call the nominal rolls. They contain a list of A's, B's and C's, and a list of "no awards", and they are for every teaching hospital and every region.

984. These are the names of people whom you naturally would wish us to keep in confidence?—Yes, that is so. I would like you to see them (Files passed to the Commission). We hand that nominal roll to these people who are interviewing us both. For instance, suppose you are interviewing a professor of surgery, we begin on surgery and say: "Will you go through the people with no awards and pick out two or three whom you think ought to have a C, and will you go through the C's and pick out somebody whom you think ought to have a B?", and there we ask for perhaps two. Every single person we ask, all over the country—and this is terribly important—goes through the whole list. He is not just given a list of names and asked: "Do you think X is better than Y?" He is asked to go through the whole list, and supposing he goes through the no awards we would say to that professor: "Produce, if you can, three or four C's, and then go through the C's and produce the B's". We have six or seven people working independently going through the list like that. Then we go through what they have evolved and you will find if we have asked them for three B's that there will probably be two that are common to most of their lists and one may be a borderline case. Then the teaching hospital elect a committee on their own which I have nothing to do with at all. That committee consists of about six people, something like that, and that committee produces a list of names for A, B and C. We then compare what the committee has done with these people whom we have interviewed and we ask the committee about the people brought forward, and so we get what is the secret of doing this, cross-sections of opinion. The whole object is to get cross-sections of opinion. When we have half an hour with that man it does not take him more than about five minutes or ten minutes at the very most to select his people and we spend the remaining

twenty minutes asking him questions about them and about other people in that list.

Is that at all clear? To launch this on you in this way is rather unfair perhaps but that is the way it is done. There are two fundamental ways in a medical school, separate interviews with at least six different people independently, lasting about half an hour each, and then with the committee elected by themselves. It is no secret that I find the interviews enormously more helpful than the committees. The committees do not talk as freely and it is not really anything like as helpful but they like it and they would feel if they had not got that committee that they were not taking part in the thing properly. That is the procedure. That applies practically to all the regions. When I say practically I should explain that in Oxford and Cambridge the Regius Professor of Physic has a great deal to do with what is done. In the Oxford region we make separate visits to Northampton and Reading, which he has nothing to do with, but in the actual medical school he has a predominant part in the machinery, but it does depend on the man, with a non-clinician it is not as easy. If you have a man like Pickering, he makes all the enquiries beforehand and knows all about it.

The only exception to this is Manchester which has a committee which lasts about three or four hours and we have not yet introduced the full system of interviews there, but I am sure it is the right system.

Supposing, as has happened this year in a certain region, one of those recommended was a thoracic surgeon. We then ask the two central assessors here what they think of this man, that is to say, the two central assessors in thoracic surgery. Therefore, on that particular man we would have the check of the university of the region and of the central specialty. In other words, we are always trying to get additional cross-checks. When we get those cross-checks, and get some kind of agreement, we know we are right. If we get three for him and three against him we feel we have to go further and get more information.

Do you want me to go into that in more detail, or is it clear?

985. *Professor Jewkes*: Would it be fair to say that in trying to maintain the same standards from one region to another that your presence as Chairman represents one of your functions in this system?—I am not quite certain I understand.

986. How can you be satisfied that the same standards are being imposed in the different regions in the appointments of A., B. and C. awards?—I think that is a very interesting question because it is terribly important. Human nature being what it is you get an intelligent man and he will say: "I do not think that man ought to have an award because he is so immersed in practice he does nothing else," meaning that he does no research or writing and does not even attend meetings regularly and it is a very valid reason if you apply it to everybody. But if you take some eminent gentleman in London who is run off his feet with an enormous practice and probably has not much time for attending meetings, and though he has written in the past is not writing now, it would be quite unfair to let him get away and mark him down for ever because perhaps he is doing too much practice for the good of his soul. Is that the answer you were looking for?

987. I was really trying to find out what method exists of establishing common standards, and I was suggesting that perhaps you are the person who operates in every region?—I think it is my job to point out that they are applying a rule which they are not applying elsewhere. That is what you mean, is it?

988. Yes.—I do that.

989. *Chairman*: In these very large regions is there any mechanism for making sure that the places in the more remote parts of the region do not get overlooked?—I was explaining it separately under regions and teaching hospitals. If you are happy about the teaching hospitals I will go on.

990. *Sir David Hughes Parry*: Does the committee as a whole meet afterwards when there has been a provisional determination in one area? Does the whole committee review the list?—Yes, but not only that, supposing I am bringing names before that committee that you are talking of, I forward to the physicians and surgeons beforehand the details and, in other words, I get sec-

tions of the committee to review them before they come, and then they meet centrally.

991. And the whole committee meets as a body?—Yes.

992. *Chairman*: When you said central assessors just now, I am not quite sure I know what they are.—I am coming to that. Can I go on now to the regions?

In the regions which we have to do separately there would be an absolute uproar if the regions thought they were being done by the teaching hospital. This is a very old tale and everybody knows it but I have great sympathy with the non-teaching hospitals because they are handicapped in many ways. They have not got registrars very often or, at any rate, nothing like the same laboratory equipment, and the consequence is that they produce papers and attend meetings at a very great disadvantage. It is absolutely essential to bear that in mind when somebody says that X from a teaching hospital is better than Y. One says: "Yes, but would they be so if the circumstances were reversed?"

When we come to these regions we do it rather differently. We again interview people if we can separately, because that is the real thing, but they always have a committee of their own.

In Wales the representatives for places like Newport, Bangor and Swansea come to Cardiff and I see them separately for about half an hour each, that is all, and they bring up the claims for their particular part. Generally, they have a committee in, say, Rhyl or Bangor, whatever it is, who have sent them names, but the individual brings them up to me. We discuss those at length and sometimes then the committee meets all together, but the best way is to have them separately.

When we go to Manchester there we had a different system which we think is a very good system but it has broken down. There used to be three regional people who were a very experienced surgeon, a very experienced physician and a gynaecologist, who had been President of the Royal College of Obstetricians; they went round the region. That was their job in life as they had finished with practice. They were invaluable but, unfortunately, one has died and the other two have retired and they

have not replaced them. I would like to see that in every region. We always have a meeting outside the teaching hospital in Manchester.

I have now come to the point you raised; when we go to Leeds we meet representatives of Hull, York and Bradford, and the surrounding places like Halifax and Huddersfield, and see them separately and see them together, and there again I think we are not going to miss people in those places or in the immediate vicinity. Our anxiety is not to miss people in say Huddersfield or some of the places just outside where there are enormous centres of population and our anxiety is about those places.

If we go to the West Country we always go to Exeter, Plymouth, Bath and Bristol, and our anxiety is not there at all because having been seven years to that part of the country we get to know the whole geography and the climate of the place. Where we are afraid is in missing someone for example at Barnstaple or Torbay—that is the difficulty. It is never the A or B but always the C, and always the remote C's. It is not the young able people, I do not think we ever miss them, you hear all about them on every hand and we are on the lookout for them, it is not the younger people but the man of 55, the man of whom 50 per cent. would say he is a C and 50 per cent. would say he is not, and there has been a dispute about it and he is left over, and now the anxiety is, is he rightly left over, and that is the whole problem of the regions in the provinces.

I think I had better run through the other places roughly. When we come to Newcastle we again have interviews with these regional men and there, in this case, they are not picked by us. They pick themselves and Middlesbrough and Sunderland and all these places send one representative each and they have a meeting and then I see them individually.

When we go to Birmingham we always go to Stoke and have a meeting there, and there we see the advisers in Stoke before the meeting, and then we go on to Wolverhampton and have a meeting there. We always have a meeting at Coventry. For several years we have had meetings at the two municipal hospitals in Birmingham and we have

had meetings at other places like Stafford but, generally speaking, that is our rule for Birmingham.

When we go to Oxford we go to Reading and Northampton.

When we go to the Cambridge region we go to Cambridge, Ipswich and Norwich. This year, a man came up to the Ipswich meeting and said he would like us to go to Peterborough. He did not think it fair that we should always go to the same place. When we have a meeting at Ipswich the Senior Administrative Medical Officer, that is to say, the organiser for the region, is asked to summon all consultants who would be available for this meeting in the area, therefore, if we have a meeting at Ipswich he summons them, and the people at Peterborough felt it was a hardship. I said that we would go next year. The same thing has happened in Tunbridge Wells and they have asked for a meeting. I think it is always wise to go there, we cannot go everywhere but I think it is wise to try and go.

I have covered Bristol, Birmingham, Manchester and Leeds. When we go to Sheffield we go to Nottingham, Derby and Leicester, and again the same thing happens as I told you. Occasionally, we go to Lincoln.

I think I have been through all the regions. The basis of our plan is to go to different centres and have people summoned for a meeting. Those meetings have nothing to do with the selection of people. At Newcastle, for instance, we have as many as 250—that is abnormal but that is what happens. That, incidentally, did not happen this year because we had to scratch it and have it on Sunday instead, but generally that is the average figure. I give a talk for about half an hour always on finance, and then they discuss it—at Newcastle, for two and a half hours. They say anything they think and bring up any criticisms either of the award system or finance generally. It takes two or three months doing this but we go round to these various places. Sometimes we have meetings at places like Truro and Carlisle but not regularly.

Is what I am saying quite clear or does it need explaining?

993. I am not quite clear what bearing the 250 people have on the choice made?

—I think that is a very rational question. It is for the ventilation of grievances largely. I think it is very important to bring them up to date with what is being done, and give them an opportunity to say whether they disagree with anything in the administration or anything they can think of which could be done. There is no doubt that in this system there is no perfection, you have to go on trying to make it better. We are always discarding somebody who does not help very much and electing somebody else in his place. We get numerous suggestions throughout the year, and some are very good, and they are all designed to make the system work better but I think in twenty years we would still be trying to improve it.

994. *Sir Hugh Watson*: Do you have meetings all over the country?—Yes, all over the place. For instance, in the West Country we go to Plymouth, Bath and Exeter. We always have meetings at Stoke, Wolverhampton, Coventry and so on, every time, but we have only occasional meetings at Carlisle and Preston.

995. All meetings of 250 people?—No, nothing like that number. I am guessing but I would say the usual number is 60. Newcastle is abnormal as they come from Carlisle and distant places.

996. Could I ask this question for the record? The file which you have been good enough to hand us starts off with an explanatory note and the first note says: "This list includes all consultants eligible for distinction awards in the National Health Service". May we take it that all consultants eligible for awards come under the review of your committee?—Yes, absolutely. Would it be perhaps more fair to say they come under the review of people advising the committee, would that not be fairer?

997. You were talking of Newcastle and you said that Middlesbrough and Sunderland were represented. What sort of people are they?—Never teaching hospital people, non-teaching, that is what you mean, is it not?

998. I meant have they got A or B awards?—Yes. The Middlesbrough surgeon happens to be an A, but as a rule they are generally B's.

999. Do they advise you about the many specialities in the area?—Yes. I

think what is generally done is this; supposing we take Middlesbrough, they will have a meeting, there are six or seven people and they have always got a list, and then the only function of the man who attends the meeting is to put that to me. It has been thrashed out at Middlesbrough before, you see. Is that clear?

1000. Yes, perfectly clear. May I ask this further question? In your opinion as a result of the various steps you have taken and which you outlined this morning, is the system by which this matter is administered reasonably well known throughout the profession?—I would say that the answer is, yes, because we have been having these meetings now for seven years and I would have thought that the . . . you are talking now of consultants, are you not, not general practitioners?

1001. Consultants, yes.—I would have thought the award system was extremely well known to consultants. After all, they are a limited body of 7,000 and scattered all over the country, and we are always talking about this, and there is no remuneration beyond their basic salary except this.

1002. *Chairman*: And would you say it is known to other people in that branch of the profession, by registrars, and so on who might eventually become consultants?—I do not know. You must remember I am prejudiced very much in favour of this system.

1003. We have understood that!—But making allowances for that I would say that if you abolish the awards the effect on the registrars would be seen at once. It is the only thing that makes this difference as far as material things go and lifts it out of a basic salary which is less than most practitioners make generally.

1004. One thing I am not quite clear about is on these local committees. How many people in any one town, for instance, Ipswich, if you like, within the profession, know who is being considered?—The issue that you are opening is that of secrecy?

1005. I was wondering if the committee when they advise, know the names of the existing participants?—I think it is most unfair to ask anybody to advise without having a nominal roll, therefore, I always ask the Senior Administrative

Medical Officer to forward a nominal roll to these people and ask them to return it at once when they have done with it, but that is not always done. The secrecy has gone so far that these regional people are very reluctant to do it, not all but some, and I have had the mortification of going down and saying: "What do you think of my list?", and they say: "I have not seen it". I am trying to put that right but that is the answer to your question.

Chairman: Yes. I am not opening the whole secrecy question but just on that point.

I think we have a lot more questions to put to you but I think we might perhaps break off now. We will resume at 2.15 p.m.

(The proceedings were adjourned for lunch.)

ON RESUMPTION

1006. *Chairman:* I think we had finished that part on these meetings on selection. You had been describing two quite separate kinds of meetings, I think, one of which was the general meetings of consultants, which are really public relations more than anything else, and the other the small meetings of committees provided with a good deal of information who advise you on who are the proper individuals for the several vacancies, is that right?—Yes.

1007. And on the whole it is fairly uniform but not in detail throughout the country, region by region.—But not in London. I have not done London at all so far.

1008. Perhaps it would be best if you did London next.—The system in London is quite different really. Incidentally, it is more difficult because in a region in the provinces almost everybody knows everybody else. In London people do not know each other in the way they do in the provinces. For example, you could have a meeting at Whipps Cross with 90 consultants and you will not find anybody knows anybody else, and that sort of thing, whereas if you go to the provinces you will find they know each other, and have done so for years, and everybody really knows everybody else's form.

Coming to London with that disadvantage you have to divide it up into teach-

ing hospitals and the regions, the four Metropolitan regions, and there is not any difficulty about the teaching hospitals. What happens there is that there are 12 of them and I write every year to the Chairman of the Medical Committee, and I ask him to send in names from that teaching hospital. He, or his committee, his committee being the Medical Committee, elect a small committee and they send in the names and I then see representatives of that hospital, generally at my house, who explain the merits of these people and the runners up, I need hardly explain to you that a teaching hospital is a big family in a way and everybody knows everybody else. They have been there for many years and almost down to the lift boy everybody knows everybody else's form and so there is no difficulty really.

In the regions we had one A., four B.'s and seven C.'s, that is twelve, twelve multiplied by ten is 120 so, roughly, for the sake of argument, we will say we have 120 awards to give to London. We begin in a rather arbitrary way of asking the teaching hospital to send in perhaps one A., one or two B.'s and three or four C.'s at the most, that sort of thing, you see, and then our other sources of information are, firstly, the three Royal Colleges. The Royal College of Physicians sets up a committee a considerable number of weeks before which prepares a list not only of the Fellows of the College but also of the regions, that is to say, it does not confine itself to teaching hospitals but does the regions too. They have learnt by experience that if they appoint a committee of men of the seniority of the President they really do not know the younger people, and at the College of Physicians they have got into the way of electing a man generally in the early forties for each of the four regions. Supposing you are doing the south-east, it would be a Guy's man possibly, somebody who knows that region, and he is appointed by this small committee to help, and the seniors deal with the A.'s and maybe the B.'s, but generally the advice about the C.'s is given by the younger members.

The College of Physicians send that list in to us and the College of Surgeons do the same. They also have a committee and in recent years they have found the same as the College of Physicians that they must have younger

people advising them otherwise the C.'s become really unknown to them, and they do that for us. They take infinite trouble. I have a letter from the President consisting of five sheets, he takes as much trouble as that himself about it. They send in that list and the Royal College of Obstetricians and Gynaecologists have another committee and they send in a list also. In addition, in gynaecology, we have two other advisers so that we rely for gynaecological information not only on the College but on these two other advisers who are both A.'s, of course.

The Chairman asked me a question this morning which I do not think I really answered properly and that was about the assessors, and that is where they come in here. There are 22, I think it is, specialties; there is general medicine; diseases of the chest; mental health; neurology; paediatrics; radiology; radio-therapy; physical medicine; pathology; infectious diseases; dermatology; venereology; ophthalmology; general surgery; anaesthetics; neuro-surgery; plastic surgery; thoracic surgery; orthopaedic surgery; dentistry; oto-rhino-laryngology; obstetrics and gynaecology.

1009. They are the ones we have on page 90 but the oto-rhino-laryngology is given as ear, nose and throat surgery. —Yes. With regard to those branches I have already dealt with general medicine and obstetrics, and general surgery, and what we do is get two or three assessors separately to advise us in each branch. For example, in mental health we get one of the heads of Maudsley, or somebody like that, and somebody who will be on the teaching hospital as their mental hospital teacher, a man who is familiar with the practice and familiar with the medical superintendents of these mental hospitals. Finally, we get help also from the man in this special branch at the Ministry, so we have three separate sources.

I do not contend for a second that doing mental health recommendations is anything but very difficult. It is very difficult to find agreement between these people practising in this branch and by its nature it is difficult, of course, to judge and assess. But with those reservations I think on the whole what they try to do is, supposing they have three or four people to be recommended in

mental health, they would try and get one man of the medical superintendent type, a man who in some way had done something which the average medical superintendent does not do or who does it a little better than the average, and then they would try and get some man more in the academic line, a man who has written something, like the man who got an A. this year, who has a European reputation. A third would go to someone who is outstanding. What we try and do is get opinions from all three advisers separately, and if we can get one name as has been this year sent in by all three, rather than separately, we feel quite happy about it, but it is not an easy branch.

When you come to neurology it is quite simple. It is a small and highly specialised branch.

In paediatrics we have two separate assessors who independently advise us about that branch. In radiology and radio-therapy we have a man on the committee who is the head of the radio-therapeutic work in the south, and he and two others meet every year, and then they meet me and we go through the whole list of names. It takes a long time but I think it is the only way to deal with a branch like that.

Physical medicine is a very small branch and there is one particularly good adviser and it does not present any great difficulties.

Pathology is much more difficult. We have our chief adviser and several others and they go through the whole list of the nominal roll. If we ask them for a name in their branch of an obvious A., and perhaps for two B.'s and two C.'s they try and provide them. The difficulty in this branch is that since they have not got out-patients, or things like that, they are rather expected to write something to lift them out of the ordinary rut and not just carry out routine pathological duties, so it makes it a little more difficult to assess.

In the case of infectious diseases this is a very small branch nowadays. The number of infectious diseases is half what it was and it is what may be called a dying industry. The same applies to venereology.

In ophthalmology I think there our task is simple. We have two assessors and what makes it simple is that it is a

rather small world, a very specialised world, and they are known to each other. A great number have gone through Moorfields, either as residents or in some other capacity, and I do not think one ought to make a lot of mistakes under that head. On the contrary, in anaesthetics, we are faced with one of the difficulties of the whole thing because at the appointed day a very large number of anaesthetists were taken over who had been general practitioners. At the other end of the scale there are some extremely expert people who invent new anaesthetics and things of that kind, and the standard therefore varies a great deal. The difficulty is something like this; if you go to almost any surgeon and ask him about his anaesthetist he gives him such a glowing testimonial you would not think there was one better in the land, and he has the choice, he obviously would not have him if he did not think that, so you are faced with what is almost like a testimonial. There is no doubt in this comparatively small branch that they are extremely expert. The difference between what it was 20 years ago and now is very striking, and becoming more so. The difficulty is that they are all expert, what you might call craftsmen, so what should distinguish them? If they wrote, that would easily distinguish them, but the great majority do not and, therefore, it is a difficulty. We have three separate advisers, men who are at the head of this, and they go through the list very carefully but I never feel it is perfectly done at the end of it because of the great difficulty of doing it, and we are always looking for better methods of doing it. In the case of neuro-surgery, plastic surgery and thoracic surgery, I think that if there is any danger it is because we give too many awards, because they are highly specialised and extremely expert. The men at the head are awfully good and they present such extremely good testimonials about their people that it all sounds very convincing, and, indeed, they are very good, but whether they get an undue proportion from highly specialised fields . . . An ordinary surgeon goes through a very severe discipline, but these people go through something right on the top of that, so they are rather a class apart.

In the case of orthopaedic surgery I think we are very fortunate because I regard our adviser on that side as more

helpful probably than any other in any field.

Dentistry, I have explained I have nothing to do with that.

Oto-rhino-laryngology; what I said about the eye department applies here I think.

I think, generally speaking, that gives you some idea of how we try to do the specialties. So, reviewing the situation in London it comes to this, that we have reports from each of the 12 Teaching Hospitals, from each of the 22 specialties, and in addition to that we have the 3 Royal Colleges.

We do not have any doubts at all about the teaching hospitals. Our doubts are in the regions and you will notice that this guidance that I have explained to you is largely central guidance, it is the guidance of a Royal College, or the guidance of something of that kind, or a specialty, and we have still got the problem of these very large regions, the South-West goes down to Portsmouth, for example, and where people know so little about each other.

Some years ago I divided these regions into about 16 areas each, the idea being to get a more intimate knowledge of the people working in that particular small area but it did not work, the reason being that they had not really got the standards that we wanted, they did not really know what we were after and if the man does not know what standard you are after you cannot just tell him, he has to have it in his bones, and so it did not really work as well as I had hoped, and so we were driven back to the empirical method of finding good advisers in each region and adding to that as time went on.

I never feel absolutely happy about the London regions the reason being the extreme difficulty of getting accurate information with standards in their mind of the more scattered places. One has always got the anxiety that one is missing somebody, not a young man of ability but more the man of the middle fifties. What we are constantly trying to do is find people who have a gift for this sort of thing in the regions and using them to do that.

I do not know whether this is clear. I do not suppose at this hour you really want much more. I have brought here all these files which represent actually what we have done and I can give you

examples, but I think it would take up so much of your time that if you are satisfied about the details it would be better to leave it. You see, the sort of thing I had in mind is this; why do we give a B? I expect that is still obscure to many of you. The sort of thing that happens is this; we go down to Wales and we find a man there who is a C, and though he is not in Cardiff, that is to say, not attached to a teaching hospital, he comes up one day every week and works in the pharmacology laboratory there, which research is well spoken of by people well competent in that field. At the same time, he is doing a first-class job in his own spot and, you see, that man is obviously an exception because in the face of difficulties he is continually trying to add to his knowledge. In perhaps a somewhat humble way he is trying to add to knowledge, and, I think, succeeding. A man like that stands out but the difficulty is if you do not find people like that.

Let us take the example of a thoracic surgeon, and for several years we have been considering him, he has been a borderline case, and each time we have rejected him and thought: "Well, there he is, a competent thoracic surgeon but when cardiac surgery came into the field the man in the same region, who is what you might call his competitor, immediately came up to his own medical school and spent weeks mastering the technique and the other man did not". In other words, one man had initiative and the other had not. After 3 or 4 years we had given the other man B, and we felt now the time had come whereby that man by his own work in his own branch deserved a B, because, after all, if you are going to expect all B's to break new ground you would not find it so you would be judging them by a standard which you were not applying to other people.

I can go on for the rest of the time doing this but I think it would tire you. That is more or less the method by which one is guided in that thing and I cannot say too often we never rely on one opinion if we can possibly help it. The more cross-opinions we have the better and, if it is possible, as many as six, and if those are given independently at the end of it you have some sort of surety. I do not think we very often give awards wrongly. What I think is the danger is of not giving an award when it is

due; that is to say, overlooking somebody, and I think all our anxiety is really turned towards that possibility.

Unless you want me to say more the last thing I should like to say is that we encourage these people, if they want to, to appeal. When I went to that meeting of the British Medical Association I put that point to them saying that if they wished to appeal we would go into it, and we had 22 appeals last year which were gone into which are here. There is a type of man who feels that when a man appeals, that is to say, states his own case, one is rather prejudiced against him, but I do not countenance that at all. I understand exactly what they feel. When a man writes in and says he thinks he ought to have a C award, for the moment it grates when he says why, but I do not believe that is the right way to look at it and we approach these appeals *ab initio*, as if at the beginning, and what it enables him to do is to state his case and bring support for it from the beginning. Generally speaking, not very much comes of it. The last time I think there were only two or three who succeeded out of that number, but, on the other hand, there were two or three who were marked to come up next year for reconsideration one way or the other. Is there anything else I can help on?

1010. Taking that last point, if two or three succeeded do they immediately get an award?—Yes, they get it, they are brought up at the meeting in December and they go into the new list.

1011. They go into the new list?—Yes. We submit to the Minister a list generally during the last days of December.

1012. Did that displace two or three other people whom you had previously decided to recommend?—No, it did not. We had places for four vacancies and they were not really necessary, we kept them open.

1013. Still on this matter of the appeal, do the profession as a whole know that at a certain date these recommendations are going to be made and does the individual know he has been recommended or not been recommended?—You mean all the people throughout England? They do not know when they are recommended, no.

1014. What happens about the appeal?—What happens is this, when a man finds he does not get an award he sometimes writes in to me and says: "What do I do?", and then I write back to him. Alternatively, he sends in a statement and I then write back and say I will bring it before the Committee. That is the way it is done. Very often we have quite a big correspondence and here (indicating) is a letter which came this morning. Here is a man writing about an anaesthetist and he is presenting the facts about a single case. That happens fairly frequently, and he is brought up again when that happens.

1015. He is writing about himself?—No, it is a surgeon writing about an anaesthetist.

1016. But that surgeon might very well know that he had recommended an anaesthetist and he may have been one of those who says: "I have the best anaesthetist in the world".—As a matter of fact, this particular member is a member of the Awards Committee and is writing about a man in his own school whom he thought had been overlooked. Those are the circumstances.

1017. *Mr. Gunlake*: I think it is common ground that one of the important purposes of the whole merit award system is a stimulation to cause consultants to become better consultants, and in the phrase you used just now, to add to human knowledge?—Yes.

1018. I think you also mentioned just now that in certain specialties a man was expected to have done original writing or original research in order to be considered for a merit award. Is it thoroughly understood amongst all consultants what motions they have got to go through to be considered for a merit award in all the various specialties? Do they know they are expected to do certain research or writing? If they do not it seems to me that this particular purpose of this system is defeated.—I think the word "expected" that I used is too strong because I do not think we can ever expect everyone in any branch to do original work; original work is so rare. I think it would be truer if I said that in pathology, which was the instance I used, that on the whole if a man wants to separate himself out from his fellows it is not as easy as for a

surgeon or a physician, and if he has recourse to writing he is much more likely to do it, or alternatively, bring up cases to a medical meeting. Your question about do they know, when a man joins the service he is given a form to study, his obituary, as it were, and that is returned and filed. It has been brought out recently in some of these meetings that that should be repeated every two or three years and that is at present under consideration. I do not know that it adds as much as they would think because we know all about the man except recent writings and that is rather fairly easily obtained. I think it would be unfair if it went out that to get an award it was necessary to do original work. I do not think that would be an accurate summary of the position.

1019. *Chairman*: No. In fact, what the Spens Committee recommended was a collection of individuals for exceptional awards in respect of outstanding professional ability, that is really what they meant. That does not necessarily mean work outside your normal job, so to speak.—This is one of the questions that it is extremely difficult to answer, but I would like to answer it in this way, that when a man writes a report a good deal depends on his literary talent and I think in our terms of reference we use the words "professional distinction" which are more sober and accurate words. I think the operative words in our terms of reference are "professional distinction," I am speaking from memory, but I believe it is so—the terms of reference of the Awards Committee.

1020. Yes, "for professional distinction."—I think that is probably a more accurate way of putting it. That is the first point I would like to make, in other words, that we are not responsible really for the language of the report. Secondly, and I think this is very important, it would appear to a fair-minded person that two-thirds of any community cannot be in the words you used "outstanding". I think that is probably true but I would like you to consider this point—again I am speaking from memory. I think there are 87,000 people on the medical register at the same time that there are these 6,900 consultants. Those 6,900 have separated themselves off from the other 87,000. I think it is perfectly fair to say that if 6,000 or 7,000 have

separated themselves from a big number like 87,000 they are in some way exceptional. They are not geniuses but a good bit above the average. I would remind you that our terms of reference really are simply to say whether they come into the upper third. Our task is to say whether they come into the upper third of consultants. If you put the upper third on professional distinction I think we are on what I call sober ground. I have tried to deal with that outstanding point.

You see, there is a ladder; a man goes to a medical school and does his first year, his second year, his third year, or his five years and he has examinations and opportunities of shining above his fellows. In the old days, until quite recently, there was great competition for house jobs. Now it is compulsory but there was competition and that competition was much greater for registrars. The point I was making was that you have a ladder which people are constantly falling off and I would think that that ladder, I admit these terms are awfully debatable, but it does confer something exceptional, I think they are a little out of the ordinary. If he becomes a consultant he has got to the head of his profession and if it is 7,000 out of 87,000 I do not think that is bad going.

1021. I would like to be sure about this. I think the 87,000 includes people overseas and a very large number of dentists too.—I am speaking from memory, it may well be so, but if they went overseas do they not go from medical school?

1022. I think, broadly speaking, the numbers are from 40,000 to 45,000. I think that is actually the number of general practitioners and of the hospital service.—Is it not true—I am asking for information as I really do not know—that there are 57,000 in actual practice, is that not so? However, my point is independent of statistics. My point is that from this very large number is thrown up this figure of 7,000.

1023. It has been put to us by a good many people that the two branches of the profession, general practice and consultancy, are not senior or junior to one another but they are level, do you agree with that?—I say emphatically, no. Could anything be more absurd? I was Dean of St. Mary's Hospital Medical

School for 25 years and all the time I was on the staff we had an entry of about 80. It is probably more accurate to say by the end of that time we had 85, and earlier it was not so big. All the people of outstanding merit, with few exceptions, aimed to get on the staff. There was no other aim and it was a ladder off which some of them fell. How can you say that the people who get to the top of the ladder are the same as the people who fall off it? It seems to me so ludicrous.

A certain committee was set up with a well known consultant in the chair and it published this sort of thing as if they were two branches of the same tree. I do not want to say anything offensive but it is quite absurd. Is there no ladder? If that is the contention what are they doing then? Why are they trying to achieve these results? It is quite ludicrous to my mind and I do not think you will find a single Dean at any medical school who will give you contrary evidence.

1024. Do not a great many people decide to become general practitioners very early on in their career?—That is said in recent literature, but in the old days I think it would be true to say, I do not know what the percentage was, but supposing half got house jobs, if that is true they were deciding fairly early, because in the old days supposing a man qualified and then became a house surgeon or physician he would then have to decide. But it was probably decided before then because he would perhaps go in for a registrarship, and if he failed he would feel there was nothing left. I suppose something like half did not get house jobs and, therefore, were eliminated straight away. I am talking of the past and I think that is true.

1025. I think you are the first person who has suggested to us that general practitioners are a somewhat inferior branch.—I would not have done it except for your leading question!

1026. You told us that the 7,000 consultants are really the cream of the profession and one-third of them are the ones who should be regarded as of distinction?—Well, you see, what is really happening is we are doing this in public and I am being drawn into a series of statements which are highly controversial and obnoxious to a very

large number of my profession, which I do not exactly relish, but since I have said it I will stick to it. It seems to me that any Dean knows that there are many cases of hardship, where men of outstanding ability, because of finance, because of marrying very young—I am talking of the past—or for reasons like that, fall off the ladder which they are competent by nature to climb; I think that is absolutely true, and those constituted the exceptions, and I have known how many there are. I do not know who has been giving evidence to you, but if you call Deans I do not see a Dean giving that evidence because the position is so self-evident.

You may say that examinations are an unworthy test. But if you say these consultant appointments are accurately made, which I suppose they are, broadly speaking, then I do not see there is any way out of it. They may be climbing an illusory ladder, but they are climbing some sort of ladder and, as I understand the contention, if you are going to say these people are exactly on a par this ladder should be knocked down and put into cold storage.

1027. *Sir David Hughes Parry*: What you are saying in effect is that "outstanding" has reference to the whole and not merely to the consultant branch of the profession?—No, to put it accurately I would say that I did not like the word "outstanding". I would have thought the two words I much preferred were "professional distinction" in our terms of reference, but if I am forced to defend words like that I would think that what you say is true in this sense, that you cannot say it is two-thirds of 7,000 but two-thirds of a body who have risen by that ladder out of a very much larger number, which number is in dispute. Is that satisfactory?

1028. *Sir Hugh Watson*: The General Practitioner Committee of the Spens Committee expressed the view that it would be disastrous to the profession and the public if general practitioners were recruited only from the less able young doctors.—Yes, I know they said that.

1029. It could be, could it not, that the word which you mentioned this morning, the word "vocation" came in here?—You mean that a man would

go into general practice rather than become a consultant because of his sense of vocation?

1030. Yes.—If a man's vocation was obviously trying to help the community, would he not have more opportunities as a consultant? I do not know really, it is a debatable point.

1031. I do not know. He is the chap with whom I come in contact.—I think it is most unfortunate that we should get into the way, or that I should get into the way of speaking of the profession almost as if one is speaking of rejects. Perhaps if one had time to think one would put it differently. Substantially, what I was trying to point out was that this ladder existed with certain rewards, and in any literature I have ever read they always speak of those exceptional rewards, and in the Spens Committee report, and the committee before it representing the whole profession, they speak of a significant minority that should be enabled to compete with the heads of other professions. It was from the committee representing the whole profession that this was taken up and agreed by Spens. If you are going to accept that there is a significant minority, if you are going to plan for them, then I do not know where this argument ends because it seems to me that is proof, that is what we are talking about, that there is a significant minority and we wish there to be such, at any rate, Spens do.

1032. They recommended adequate rewards to practitioners.—Yes, they do. I suppose it would be perfectly fair to say that there were two Spens Committees, one for general practitioners and one for consultants, so I would suppose you would not expect them to be absolutely in agreement, in fact, it was said they were rather antagonistic, perhaps that is not the right thing to say, but they were not completely in harmony.

1033. *Chairman*: They say in effect they must be given the opportunity to earn incomes comparable with other professions.—Yes.

1034. It would seem that in fact in some of the specialties more than a significant minority, during the course of their career, quite definitely a majority, will at one time or another earn a distinction award.—You are thinking of things like thoracic surgery?

1035. No, the big ones like general medicine. Is that not so?—This is coming back to the statistical thing, whether it is two-thirds or half. That is what it comes to. It has been worked out statistically and I believe it comes to between one-half and two-thirds.

1036. I do not know about that but I think it is certainly over one-half.—Quite.

1037. What you think is that over one-half of any one branch of the consultants should be . . . —I tried to answer that a moment ago. I regarded this 7,000 not as half but a much larger number. That is my answer to your question.

1038. *Professor Jewkes*: I wonder if I could at this stage ask what your views are about the possible inclusion of other groups? It is sometimes suggested that it ought to be extended first of all to administrators pure and simple and, secondly, to people engaged on research but not really engaged in clinical work. What are your views about that?—I do not know that my views are worth having on the administration because I do not think I have really seen enough of it to talk about it. That is a very separate field. We, in the merit awards, are precluded from what I call giving marks for administration and, therefore, I do not know. In regard to research I am in full sympathy with that. I think any addition to knowledge is the highest work anybody can do. I would have thought so. You are thinking of non-doctors, are you?

1039. Yes.—I was asked to go to the Isle of Man to plan an award system and others whom I think are appearing before you later have been asked to go to Northern Ireland for the same purpose. This system is spreading and it may spread to the other groups you are thinking of which I think would be entirely to the good. I do not know the finance of it but really that is a Vice-Chancellor's problem, is it not?

1040. *Chairman*: Coming back to the other matters. I think there is one question I am not quite clear on. Normally, is an A. award given from those already enjoying a B., and a B. award normally from those already enjoying a C. award?—Yes.

1041. So that makes it easier to take a proper view and take everything into consideration?—Yes. I should be

distressed if in the course of these questions and due to my giving quick answers I am reported as saying that there is an inferior section of the profession. I have spent three-quarters of my life as a Dean amongst students. I am entirely devoted to that element, and if it goes out that I look upon the general practitioner as an inferior animal I shall be extremely distressed and it would be quite inaccurate. I made these remarks off the cuff, as it were. I do say there is a ladder but I think that ladder can be maintained without making derogatory comparisons. I think there are men of great ability in general practice, of course there are, as everyone knows, and in the North of England, where I was for many years, the level of general practice is very high indeed. I just want to make that point because I do not want to be misunderstood.

1042. I was hoping you would feel something like that because it is very much more in line with what other people have said.—I do not want to retreat for a second, because of fear of consequences, from the fact that there is a ladder. I think every person at medical school knows that. Whether the ladder is properly administered is entirely a different question. That is not my opinion. Whether these registrars are accurately picked, whether house officers are accurately picked, whether examinations are good that is entirely irrelevant to my argument. The only thing is that we at a medical school are always looking out for the boy of promise. I remember distinctly the Dean in my time asking me to try and bang on and I said I had no money at all: I remember the efforts he had made and he must have done that to lots of others, and I think that is what is done. No doubt in the past there were far more people who went into practice because they could not afford to hang on, as it is called.

1043. *Professor Jewkes*: Could we put the question in another way, Mr. Chairman? It is clear there have to be general practitioners and there have to be consultants. Would you have said, Lord Moran, at the moment, quite apart from the levels, that the relative earnings of the two groups are about right to keep the balance, is it a healthy one for the service as a whole?—I do not want to be drawn into a lot of controversies

after the recent experience, but I must tackle this question because it is a perfectly plain one. I have to go into it a little. In 1954 two years had elapsed since the Danckwerts award. I came to the conclusion that there was no longer any chance of the consultants getting an award. I expect you already know that the procedure was this: the general practitioners approached the Colleges, and asked that we should not bring our case forward until they had got their one out of the way. I am certain that was in good faith. We took that advice and then we were told by the Government, never having had any contact, that they regarded the Danckwerts award to general practitioners as the end of it as they did not know that the consultants were going to come in in 1954. I went to the Cabinet and said you have upset completely the balance between the general practitioners and the consultants. I based it on no other argument and I said I have no political influence of any kind. I thought you might consider it on those merits. They took a year doing so with sub-committees and they eventually gave us £3½ millions. That was nothing more than salvage from the mess which ought to have been settled at the same time as the general practitioners. It was not settled and I salvaged this. We were going ahead at that time without any details. I simply made this request. When it was granted I went to Sir Russell Brain and he took it on and made it official. What I want to make clear is that we had no backing, we simply put the case and I believe they did it solely on the basis of trying to restore the differential between general practice and consultant work and that is the award, they got it on those lines.

I say that because I believe Sir Russell Brain in his evidence very generously covered me up. I have been accused of making an extremely bad bargain and I think there is substance in it. The B.M.A. said it was the most undemocratic way of doing it and I think two years had elapsed and I was under criticism; Sir Russell Brain, to whom I have handed it over, has felt he must more or less back me up and he has generously said he was satisfied with the relationship that was left. Of course that was really generously covering me because nobody was satisfied. I do not know the rela-

tionship between general practitioners and consultants financially. I do not think anybody knows. All we can say is that it is not sufficient at the medical schools to make a man want to go on at 24 years of age; perhaps he decides he has to go on ten or fifteen years like that on a poor salary with no certainty of advance at the end of it, that nothing will happen and no retreat if he fails and that is a very serious state of affairs. Therefore I think there should be a differential and I think if there is not you will not get recruits. Incidentally the recruits to senior registrars are falling off, and I think you have had the figures.

1044. *Chairman*: Do you think it satisfactory, Lord Moran, that unless somebody gets a distinction award they should reach their ceiling at 40 which, I think, is about the date or would you think, as has been put to us by someone else, that it would be better that there was a bit of progress for a longer period even if it meant less in the earlier stages?—It is a difficult question to answer. I suppose it is the relative merits of seniority, is it not? Should a man be paid more than a basic salary if he is not thought, rightly or wrongly, to be of exceptional merit? That is really the question?

1045. It is put, I think, as payment for experience. I think it is a good deal of the feeling of the doctor himself that he has not reached the end at the age of 40. Maybe the hope of the merit award covers it well enough. Have you a view on that particular point?—I think you are looking for efficiency in the profession pure and simple. There is no doubt the present arrangement is most valuable. I suppose it ought to be considered is it any hardship to the average man in the consultant ranks. It is difficult to say. I would not have thought so but I am not strong upon the point at all. I think probably the present system acts as an incentive, rewards either one half or two-thirds, whatever the figure may be, it is a very considerable number, and gets work out of men. I think perhaps it may be agreed there has been, not only in medicine, but elsewhere, a certain slackening of efforts in certain aspects. Medicine is not immune from that either and I think these things, quite apart from the fact that I am in favour of them, demonstrably they make men keener and if it

applies to as many as two-thirds it is a very valuable incentive to have two-thirds of the consultant profession what one might call "on their toes".

1046. Would you think it does apply to two-thirds? It is realised in the profession that when people get to 40 at the end of their normal ladder that within the next ten years the chances are about two to one that they will get something more if they work very hard, try very hard?—At these meetings I am always saying to the younger people providing a man is keen and intelligent in his lifetime he ought to have a very good chance of reward. I believe that to be true.

1047. In his lifetime normally means between the age of 40 and 50, probably most of them are between those ages who get to the ceiling?—Quite a number get it at 53 and 54.

1048. Between the ages of 40 and 55?—Yes.

1049. There is one thing I do not think we have covered very thoroughly, it is difficult to do so, to decide what are the criteria of merit or distinction. Perhaps it is difficult to define any closer what are the criteria accepted by the committee?—I have tried to put it graphically by my reference that if a person had illness in their family and supposing it is surgical, I imagine what one wants is a surgeon of good judgment. I think that is even more important than technical excellence. If you have a man of excellent technique and good judgment you have gone a long way towards getting a safe surgeon, and I imagine those two qualities are at the back of anybody's mind when they are adjudicating upon any surgical man.

In regard to medicine where technical dexterity does not come in in that way it is very difficult. It is largely a question of wisdom and things of that kind and I would have thought judgment is the supreme quality of the physician. Of course, I always contend I am perfectly incapable of judging myself whether a man is a first class ophthalmic surgeon because I cannot tell how he performs an operation: you cannot get near enough to know what happens. It is one of the problems of the world which is one of the real tests and there again it is difficult, you can go through the various branches in this way and these qualities.

I think, would probably occur to any doctor picking that kind of man for his family.

1050. I do not suppose you can ever have anything very precise or complete on this in most of the specialties, there must be a certain intangibility, but the important thing is that the profession itself should be satisfied that justice is done, is that right?—I think that is perfectly true.

1051. Of course, the profession cannot know if justice is done if they do not know who is getting it?—I think what you really want me to talk about is secrecy.

1052. May we take one or two questions and come back to that in a moment. I was going to ask you to say whether in round terms whole time consultants got about the same sort and proportion of awards as part-timers?—The answer to that is the committee have not the slightest idea when a case comes before them whether it is a whole-timer or part-timer. The only exception is a professor of surgery who is well known. If the man is not well known we have not the slightest notion, we do not provide it, we do not think it should be provided and therefore there are no exceptions to what they are doing in that way. If it may be true, you are rather suggesting that the whole-timers have not as many.

1053. No, I was asking. I do not know.—I do not know either.

1054. As a matter of fact whether it is about the same or not?—I do not know but I would have thought that probably—I am speaking very roughly—the majority of consultants are in private practice. I do not know if that is so, I would have thought so.

1055. The majority of consultants are, yes.—If that is so, it may be that a great many of the leaders are in part-time practice. I do not know if it is true. I am just suggesting a line of thought. On the other hand, the professors of surgery and medicine who are whole-timers are right at the apex, I do not think we have anything better so I think you would have to divide your whole-time into all sorts of categories and I have not any evidence statistically or otherwise to answer your question.

1056. It is not one of the decisions that you can take into account at all?—No.

1057. Then if I may go back to the question that Professor Jewkes was asking just now, has there ever been any request or suggestion for an addition to the sums given as merit awards?—I have been approached about this before and my answer has always been the same. I would have said that any committee that investigates this question, that is before this Commission was appointed, must decide firstly whether they think it is beneficial to the efficiency of the profession. If they decided yes they will no doubt want it to remain as effective as it has been in the past, and if they are not to have any betterment it will soon not be so. In other words, they have to decide if this addition is effective to the profession, if they do I am sure they will not want it to peter out and become less and less effective.

1058. Just following up from that, I would like to ask you for your own view. In the light of your experience would you feel the addition of the three categories, A, B, C has been right?—Yes, I think so.

1059. And the whole of the proportions which are 1: 4: 7 I think you said 1 A, 4 B, 7 C, has been about right?—That is very difficult to answer. I do not know exactly how one judges that. I accept that as a thing that works very well.

1060. If you were deciding again you would probably arrive at about that?—On my own I would not suggest any alteration in that.

1061. Equally that the relative amounts for the three categories which are £500, £1,500 and £2,500 are also about the right stages, would you think?—An answer to that entirely depends upon whether you feel that the importance of getting the right recruits by what you might call some plums at the top should outweigh the general bait. Some would have the C's bigger and the A's smaller but I place some importance to having something at the head for the materially minded to be rewarded by, I think it is important.

1062. I was asking your views as to whether you think those steps are about right?—I think so, I would accept that.

1063. Should we go on next to this question of secrecy?—There is no

doubt at all that this question of secrecy is the stick with which those who do not like the awards have beaten us. I think it would be fair to say that if an objection is raised at the meetings we have over the country it is usually about secrecy. I think that is fair, and that being so I think it has to be considered very carefully. We do not as a committee mind whether it is secret or not. I think that is probably fair, but in the early stages, the first year, we had meetings all over the place, we invariably asked their views on this subject. At that time there was a very large majority in favour of secrecy. What happened at one place seemed to bear this out, because for some reason or other the award became known in a comparatively small place, whereupon some members of the public went to that hospital and asked the names of those who had the awards, and when they were asked why they said it was because they wanted to go to them. That is surely wrong. It is not the object of the award system to direct channels of practice. Furthermore, as you know, the men are given awards for more than clinical judgment. These people coming into this hospital might be given the name of a C who really got it for research. In other words, the public might be completely misled. I do not see if what I am saying is true how it would be easy to work this system if the public are really going to be directed by it in their preference, and that raises the question can you let it be known amongst doctors, which I would personally like to do, without the public knowing it. That, I believe, is quite impossible. It gets into the Medical Journal, and then these lay people search every week and I have suffered bitterly from this. You cannot state a thing—what I said earlier this afternoon will be everywhere, I know. Therefore I think what I am saying about this secrecy is valid. I think that is the first point.

The awards committee listened to all this evidence and they went into it very carefully. They decided on 27th January, 1949 that consideration for awards should be strictly confidential but that members were at liberty to discuss questions of procedure with the Colleges and Corporations.

It is rather interesting that the Ministry had a memorandum on it which said the list of awards was marked confidential

because it appeared to the Minister desirable that Boards should treat it as information not to be disclosed more than is essential for administrative purposes. The Board will no doubt feel that any general application of the news might lead to misunderstanding by inducing patients to judge the quality of the medical treatment they receive by the rate of remuneration of the consultant. Such an inference would be unjustified because matters other than clinical ability would direct an award on occasions. I think they adopted the same line. It is always difficult to answer this question about secrecy because it is generally put in a rather exaggerated form and the experience of the Commission on these points is probably better than mine. I believe that there are examples of this in every walk of life. Reports on officials in the Government are confidential and I think the only difference that can be found anywhere is that, I believe, they can demand to see them. I believe an officer can demand to see his special secret report. Is that so?

1064. *Mr. Bonham Carter*: He must see it officially.—That is the difference you see. I would have thought even in the Civil Service such things are not unknown and there may be differences quite unknown to me in these reports as to how far they are seen by anybody except the person concerned. I do not think that there is the slightest objection to the man himself knowing these things. Indeed, I do not think there is any objection to the profession knowing, but I think there is the very greatest objection to the public knowing, but I do not know how you can let the profession know without something leaking out to the public.

1065. *Chairman*: You did say earlier that one of the best criteria really for deciding who is worthy of a merit award is to say who is the person to whom I would go if there were illness in my family?—Yes.

1066. That is the public estimation. Everybody who thinks about it will think that a certain person is more meritorious than the rest. If that is so, if it were known that that particular person was getting a particular award, it would only be saying that justice was being done?—How would you prevent the public going to these hospitals and blindly accepting the award system as

their guide? That would lead to such a furore among the non awardees, you can see that. Supposing you had a town of 30,000 or 40,000 inhabitants and suddenly one hospital in the place began directing practice to section A to the exclusion of section B. I think that would be intolerable. I may be wrong, but it seemed to me very likely to happen.

1067. *Mr. Bonham Carter*: Lord Moran, an earlier witness on this point said that one of the difficulties was that a senior man would not know whether one of his own juniors was in receipt of an award and he complained on that score?—I do not know. Let me put it this way. A certain medical school in London in the first year was asked to appoint a committee to put names to the awards committee in respect of their staff which was about 50. By ballot they elected three people and they decided that the names of those three people should be known to nobody on the staff because they thought it would not be fair that those three people should receive all the onus of picking these people. If you transfer that surely in giving these awards with the least amount of friction, if you have to give it to a junior and pass over his senior, you do not want everybody to know that and to draw attention to it. It is sufficient punishment, if he wants punishment, that he does not get the award, he does not want criticism with it. Do you not feel that?

1068. Yes, I see your point.—That is the point. I would have thought that the relative amount of friction has been very small really as far as one can make it, but I am sure it will be increased if we bring these things more into the light.

1069. *Chairman*: There are several possible sources of friction, either from secrecy or from the reverse, some of which can perhaps be removed. For instance, all that you have said about geographical spread out and the care that is taken to see that the different parts of the country do get, provided there is the merit there, an equal chance of getting an award. We have not really covered the question of the difference between specialties. We have not covered either the question of whole or part-time consultants on which there may be some feeling and we, none of us, know the answer. Then there is the question of three or four people in the

same specialty each thinking they are the one who ought to get it and if they knew who had it there might be increased friction rather than reduced. If it were known how many people in each specialty were getting awards would you think that would act as a deterrent at all, or as a discouragement in some specialties?—I could answer that. I think you did get some particulars.

1070. We had some particulars but we do not think they should be brought up now.—I should think probably if they were made available to the Royal Commission that would be all I wanted to say on the subject. The difficulty on geographical spread is nil. We ought to be able to get that as far as the merit allows it. The difficulty in specialties is not nil. I seem to be spending a very controversial afternoon, but one cannot pretend that the discipline of a surgeon, which is very, very severe, is anything comparable to some of the other minor specialties. It will be different in 15 years' time when the discipline in regard to anaesthetists will have gone through. It will be just the same as it is for the surgeons. They have laid down the most exacting regulations. In 15 years' time it will work quite well. A senior anaesthetist said to me: "I entirely understand the position. A very large number who were general practitioners came into the service and had not the higher degrees or anything of the sort and they naturally cannot expect really to do as well as people who have the higher degrees and have been consulting anaesthetists all their life but that will all be set right in time." In other words, I am saying that if you take the specialties you will find a certain number who have not got as many awards as the surgeons but that in time will right itself and that applies to what the dentists said to us. Again I am quoting my own figures and probably I would be wiser not to, the dentists came to us in the earlier stages and they said they would like to be in on this merit award system. A man who spoke to me said that they did not feel that they were going to play a very big part at first but they wanted to be in on it and in time they will. I think that was an extremely rational point of view. They had dentists of various calibres, some very good and some not at all good. They felt they might not get many awards at first but they wanted to be in

when the time came. I think that may apply to other specialties.

1071. You would feel there was a particular advantage, on this particular aspect, in secrecy for the next few years, 15 years or so?—I would go as far as this: when I go round the country to these meetings which are not entirely just to establish good relations, I take the opportunity of answering any questions and if I can I always get the help of a man like a senior anaesthetist who is a responsible man and put these cases to him telling the facts. They have been extraordinarily good at seeing it. It is not from them that any opposition comes at all. If you took the men in their Faculty and they gave evidence beside me they would endorse what I have said. Such criticism as comes is not from that part, it is the other end of the tree.

1072. *Sir David Hughes Parry*: I wonder whether I can put it from another angle. It is very important that the awards system should have the confidence of the profession and generally of the public and in seeking that result one must consider three aspects of it that may be secret. First of all, the criteria that the committee has; secondly the way in which the awards are made; and thirdly, the persons who ultimately get the awards. I should have thought that it is possible in the first instance to make known the criteria fairly generally without undue secrecy, and secondly, that the manner in which the awards are made might be made public, but that it may be desirable to keep secret, for the time being at any rate, the names of the persons who actually get the award. I should like to get your reactions to those three different problems.—I would begin by saying that having been fifty years a doctor I have never seen anybody or talked to anybody who would not have said that if the Royal Colleges and the British Medical Association were in agreement on a subject they could be said to be speaking for the profession. Since this Commission was appointed there have been arising various splinter groups who might be likened to the Suez rebels in the House of Commons, but they do not cut any ice with the profession. It is the most astonishing fact when I see the Press taking them seriously. The Royal Colleges and the British Medical Association have stood in the eyes of the

profession for the profession. If you had asked me to believe a year ago that a group of fifty or sixty-odd consultants out of the British Medical Association would have unanimously passed a thing in favour of awards I would have thought you were dreaming, but the three Royal Colleges and the B.M.A. unanimously endorsed this. That is, I think, a very surprising event. Surely the profession and the public will trust us to be sensible enough if we have their confidence now. You speak as if it is in the future that we will get this confidence. The confidence is there. As I go round to these meetings I am subjected to a good deal of heckling and we have often put the thing to the vote, and there have never been more than three or four against it anywhere over the country. It may be that some people did not bother to vote and so on but there is not the opposition in numbers that is represented at all. I think this is a thing that wants stressing because we have spent seven years trying to answer objections and questions and going round seeing the most difficult problems. I think you will find if you go to responsible people anywhere in the profession that they will speak of the success of this. I believe they will. I do not think the attitude is just of my being seized of the importance of the award system.

We are always answering the question about criteria when we go round the country. We do therefore constantly put that before the profession and we have great difficulty in making it precise. I think a lawyer would make a hash of what we are saying because it is not very precise at all. But it is the best that can be done and I think they are satisfied at the end; I do not think we could put it to bigger audiences than the profession. I do not think it could be done. It is hard enough to do it to the profession. What would happen to the public I do not know.

The other question was that you really wanted the criteria made public and the way the awards are made. At almost every meeting we tell them how the awards are made. At every meeting for practically six or seven years. They must hate the sight of me when I get up and say this so we cannot say it is not known in the profession. Every member of the profession, and also the S.A.M.O., has an opportunity of going.

If he does not go it is his funeral. The whole profession is summoned at one time or other to these meetings, very often held every year, and they get this jammed down their throats; they get the opportunity of saying it is not so. I do not know if it is convincing but it is the best I can do.

1073. *Chairman*: Could you say about how many meetings of this kind you attend in a year, perhaps 30 or 40 or even more? You mentioned Newcastle one and Leeds was three.—I should say 30, I am just guessing.

1074. So it probably means—again in round terms—1,000 or so people a year at least who have come to these meetings?—Yes, about 250 go to the Newcastle one.

1075. But you said that was an exception?—Yes, that is true.

1076. But it is over a thousand, quite a lot?—Yes.

1077. Would that be only consultants or would it include registrars?—S.H.M.Os. are always appealing to be present and I do not interfere. They generally are, because it is the local people who organise it.

1078. *Sir Hugh Watson*: Could we take it, Lord Moran, that all the consultants and a good many potential consultants throughout the country have the opportunity at one time or the other of attending these meetings?—Yes, they all have the opportunity. I suppose there may be some areas which perhaps do not have the opportunity. The instructions are to summons those who are geographically available. It is quite conceivable that some areas may get missed, but not many.

1079. *Chairman*: Would you say from your experience that knowledge of the scheme, its methods and administration and so forth is spreading, that on the whole people within the profession know better than they did three years ago?—I think a man like Sir Horace Hamilton could probably give you a more detailed view. He goes round and he is trained to observe these things. I think he would say there had been a very considerable move that way only perhaps in the last year. I think you might say in the last year and a half there has been considerable medical unrest which perhaps shows itself a little in

the meetings. I think there has been a more critical atmosphere because of the genuine uncertainty. I think that is probably an accurate way of answering it.

Mr. Chairman, I do not know what time is available. I would rather like to bring up one or two things. It is very brief but I am tremendously interested in two things, one is the machinery for reviewing remuneration and the other is the registrar problem.

1080. May I just make sure that no one has any questions on the merit award system. We are very much obliged to you for covering such a very wide range today. Perhaps you would kindly deal with your points now?—What I feel about this arbitration is that if we are going to have these sorts of annual scraps in public it will destroy any sort of confidence in the profession altogether, whether we are right or whether we are wrong. Ten months ago I wrote to "The Times" suggesting that we should have some reform of the arbitration machinery. I did so partly because I did not want this to appear in public every year and partly because the Whitley Council has lost the confidence of the profession. I am not associated with it and I cannot say rightly or wrongly but it has happened. It seems to me that the Whitley Council have both the staff side and the other side and they have to agree before they can go to arbitration. They never do agree in any substantial problem. The reason is that the Ministry, just like the Russians, exercises the veto and the result is that there is very great discontent with the Whitley Council machinery which incidentally does not affect the general practitioners. What I had in mind was what had been done for the Civil Service, which is on pages 90/91 of the Civil Service Royal Commission Report and I am sure you all know it. It is a committee of five members appointed by the Prime Minister who would keep under constant review, not sitting constantly, the remuneration of the profession. I am not competent to do any of the details or anything like that but I went to the Ministry at this time and to my surprise they told me this had not been brought up at all at that time. That was disconcerting because I believe if we got any solution without permanent machinery the cost of

living would go up and we would be right back into trouble. I do not mind what machinery is put up but I think we must make an attempt and, if the general practitioners will join us in this I am sure the consultants will want it. I have nothing more to say about this particular problem. It is really to put it before you as one of the great urgencies of our needs.

1081. Would you suggest that if something on the Priestley Civil Service line were possible for the hospital service and the G.P.s for the main problems, something like the Whitley Council machinery would still be quite suitable to go on and deal with all the more or less day-to-day problems that arise?—From the little I know about it I am sure you are right. I do not think you can ask a body, at any rate with people such as Sir Oliver Franks on it, to go into minor things. We have to have a central committee for the important recommendations and minor things may have to be dealt with by other machinery.

1082. Of course you realise that the committee dealing with the Civil Service question is only advisory, that is to say that the Government has not abandoned its own power to say no?—I realise perfectly. My only hope is that if you get such an official body the Government might be sympathetic. I realise that you cannot have anything except advisory machinery.

1083. Now would you like to continue with your other point?—I am very bothered about the senior registrar problem because of its importance and because I do not think you can be dogmatic about it. It is very difficult to know but the problem that is worrying me is this: we have in the senior registrar problem, with which you are familiar no doubt, something which is extremely injurious to recruiting, much more so than people realise, and at the same time is causing personal hardships of such a nature that I would like to bring it home to you in this way. When I went round to these meetings this time where we exclusively confined ourselves to finance what nearly everyone raised concerned a man's finances; to my great astonishment at every single meeting without any exception the only thing they seemed interested in was this senior registrar problem. As that did

not affect them personally I think the unanimity was extremely surprising. You are getting men of 39 going up year after year for these jobs with considerable background, all with high degrees and with experience and with no hope. I want you to look at it for the moment from the recruiting point of view. Supposing you place yourself in the position of a man leaving school at 18, qualifying in the minimum time of five years, that is 23 years of age, then doing his year's compulsory job—age 24. I do not know whether it is fair to put in two years for National Service as that is going out, but the man is at 24 plus because if he fails his exams, he sits again. Then he is faced with the question is he going to specialise or not. He is a man with a wife and two children—everybody seems to have a wife and two children in all these arguments—and he has to say to his wife this thing: she says to him: "Well, what are the chances?" Quoting the words of the Royal College of Physicians Report it is now, more often than not, not the exception but the rule that seven, ten, fifteen and even twenty years are spent in training and at the end of that time he has—in their words again—no assured future. In other words because of the disparity of the new consultant jobs as compared with all these large numbers of registrars, the chances are that he is quite likely not to get one at the end and if he fails he has no line of retreat because, again they say in their own words, that his chance of getting into practice is almost negligible, the general practitioners for some reason or other do not want highly qualified men. In the old days I remember a man failing to get on his London school: he had all the degrees and he went into practice with three others and he was an asset, doing all the medicine of the firm and he got on the local hospital. But now they cannot get on the local hospital, they are no longer an asset and so he has no line of retreat. When I think of what this man said to his wife, that it may be ten, fifteen or twenty years, and he is now 24, and that at the end nothing may happen and if nothing happens there is no line of retreat. I think these are very solid facts, they are very forbidding facts. If that is all true he says to himself: "Well, what is to be done?" Unless that is altered it is not going to be very long before

the consequences are felt. The number of people applying for the post of registrar is falling quickly already and in one London medical school it has fallen in five years from twenty to ten, and at another non-teaching hospital it has also gone down about the same proportion.

That is the first thing about which I am worried. The fact is that you have these men going round on this period of training. I do not know how it is in all the other callings but it is surely an anomaly that a man should be 39 or 40 and still a trainee. It seems to me contrary to reason and I cannot believe it is right. Although I am certain the Ministry has not the slightest influence on appointments, still they can be criticised, and are criticised, because it is to their advantage financially to employ this highly skilled labour at under consultant pay for year after year, the period being decided by the said Ministry until they appoint new people.

1084. *Professor Jewkes*: I find it very difficult to understand this point, Lord Moran. If one were to say that there is a shortage of consultants on its own merits that would be one thing that we would have to take into account, but if one were to say you ought to create more consultants simply in order to provide consulting employment for senior registrars that is quite a different point?—I see that.

* 1085. Which point are you trying to make?—Both.

1086. That there is an absolute shortage of consultants?—I do not think anybody who was at all informed would admit that consultants are sufficient in number; one knows that senior registrars are all over the place doing major surgery without supervision, in many areas without any consultant surgeons. What was your second point?

1087. That if you can provide more consultants then you hope to solve the senior registrar problem.

1087A. *Chairman*: The second point was whether you want to create consultants who are not wanted because there are senior registrars going begging—I do not think the country would tolerate making consultants like that but I would just like to make it clear how this situation arose. During the war years when demobilisation came in the Government said, I think quite rightly,

these men have spent three years with the battalion or regiment or ship, they cannot go into practice unless they have refresher courses and so they subsidised them and for one or two years they were paid by the Government. What happened? They all went up for higher degrees. I think I am right in saying that in one year we had 2,000 people at the Royal College of Physicians going up for the membership examination. In the old days you went up once, twice and then you gave up. These people went up four and five times and so you got a tremendous pool of consultants ignoring the laws of supply and demand. The Government was responsible for that. I do not blame them. I do not think they could do anything else. But surely, having created a temporary abundance one would see that it could not go on for ever. After all that is doing harm to recruiting, not only in regard to registrars but recruiting to the profession. Surely if consultants are to be made, as I think we agree they should be, it would pay them to make an S.H.M.O. a junior consultant. It would not be a big sum and they would get people who are worth it. They would have solved problems that arose from none of their wishes and they could start afresh. I do not believe that financially a consultant has many advantages. I say that because I am thinking of some of the places that I see as I go round, but there are places which are very efficient and very good and they cannot get registrars at all. The profession has worked itself up tremendously over this. I do not think I am exaggerating, using language like that. In going all over the place I find it is universal right through the country. If that can be solved we can start afresh and then we shall see if we cannot get in for example the pathology lab. a man going into it without high degrees, without much experience, he is not a consultant and nobody looks on him as such; he remains a pair of hands. But the whole difficulty in the N.H.S. is that they have mixed up two people, the man who is a consultant both by degrees, experience and ability, and the man who never will be a consultant because he is just a pair of hands. They have got the two confused. That is leading the S.H.M.O.s to be a terribly unhappy class. They do not share in

awards, they do not see any future for themselves. In every way they are discontented.

I was originally present at the Ministry committee when this question came up and it went round the table. They all said this is necessary. They were all thinking of a pair of hands. When it came to me I said: "I am sure you are right but have you thought where it is leading? It is leading to a large number of people doing consultant's work at sub-consultant pay and it will lead to all sorts of unpleasantness." We were told that it was a temporary measure, there are 2,600 of them. There are 888 new consultants now, there has been a great expansion in psychiatry, and in radiology. I think I am quite accurate in saying that. This figure of 888 is since 1951. My figures for surgery and medicine are not from 1951 but from 1949 and there are 61 new appointments. We had 56 in obstetrics and about the same number, that is eight a year, for these very important branches. These are all Ministry figures. I think that means that is where the crux is, in medicine and surgery. It does not mean to say that there have been a large number of consultants made, there have been very few made but an immense number of registrars. I would pray the Minister to settle the problem. It is causing discontent out of proportion to its real worth. These people feel they have no future and they have nothing for which to work. That is the problem but the remedy seems to me to cut the losses and to do this. Get this out of the way at negligible cost and put our minds to solving what is very important.

You will find staff people in some places having to do house surgeon's work and many have not got English house surgeons at all. There is nothing in between. They have to do all the chores. It is not a working proposition.

I do not know whether you would like to ask me any questions?

1088. *Chairman*: I think we would. There are two discontents I think with the senior registrars, one is the question of money, the other is the question of security, the fact that they have no security from year to year?—I am sure the security is the thing which is worrying them.

1089. That is really the point, that provided that they can have some promise of tenure a great deal of the worry will go?—I am afraid your argument is leading to this. Do not create a state where there is confusion whether a man should be a consultant or not because there is dilution of labour. It has gone through England so many times. If you introduce a class of junior consultant you are going to interfere with the whole of the recruiting of consulting medicine. If you are going to have a junior class for those who do the job of a consultant the Treasury is going to be on their tails. They would be inhuman if they did not submit to some sort of pressure to make too many junior appointments.

1090. May I ask what kind of security you would think ought to be given to the senior registrar who has not the full consultant qualifications?—He never will have them?

1091. Yes.—I thought I had tried to answer that. I know you have to do it in two steps. You have first of all to get the profession's confidence in this way. They are terribly suspicious that they are going to use this labour as they have. Get that set right and then I am afraid that man will have to go back to being a pair of hands in a peripheral hospital. It is a good job but he will never be confused with a consultant. You must not call him registrar or anything confused with registrar. Whatever you call him you have to make him a class apart.

1092. May I ask what you thought he should be called?—I would prefer to call him X.

1093. You feel that the main trouble is security?—Yes, I do. But not security at the price of discontent.

1094. In particular you do not want to see a great number of consultants created as a means of getting over this?—No.

1095. You say that there may be some who never will be of fully qualified consultant ability but they have got to go somewhere else?—Yes.

1096. I am asking if you have an idea to give us as to what?—I do not think it is the right order. I would say solve this problem and then let us put our heads together, one, to think out the thing; two, the duties that this man is going to do; and three, his area of work. I think you would find that would mean

everywhere because they are wanting them everywhere, what I call the peripheral hospitals which are very understaffed. I do not think you will get it until you get this other out of the way then I think the three things will be done.

1097. Is it not so that there is a tremendous queue which you get in the registrar and senior registrar jobs at some of these very well known teaching hospitals where you may have the benefit of working with the greatest teachers, be right on the ladder, and in the limelight, while at the same time there is probably greater security on the periphery?—The answer to your question is this: there is, as you know, a very partial arrangement between teaching hospitals and the peripheral ones and the man does a year there and perhaps a year elsewhere. It is quite wrong that the teaching hospitals should not play their part in solving a problem that is as important as this. I will not be popular but the teaching hospitals must play their part. They must part with the registrars. A man wants to settle. He is so anxious about the future, he thinks that if he stays at the teaching hospital he will not miss a chance of advancement and he will not go so you have them all congregating there. You cannot compel the man to go but you can put pressure on the teaching hospitals to do something of this sort. I think that is the answer to the question. It could be done quite easily. It is a question of trust really. If the registrar felt that he does very good work in this place, if he went outside to another hospital he would not have quite as good supervision but he will get more responsibility and better material, I think if he were told he would stand just as good a chance he would do it. If everybody did it there would be no disadvantage. He is afraid now that if he went there are other people who would stay and get his job.

1098. That seems to play a very large part in the problem?—I feel strongly about this thing. I hate overstating any case but I do not think you can overstate this problem from the point of view of the consultants, they feel it so acutely. I do not see how we are to settle it except in that way. The real trouble is that the profession as a whole have asked the Ministry for a survey of the hospitals to find out what hospital work is being

done by S.H.M.O.s, the senior registrars who are doing consultant work, that is what they want the survey to investigate. So far they have not been able to get sanction for it from the Ministry. I feel it will come. When they get that survey, then I think we are a long way towards getting these people made consultants, and then we come on to the really knotty problem you have raised.

1099. Assuming it is a knotty problem, it has been tentatively suggested at any rate that perhaps these people, whom we will call senior registrars for the moment, should have a suitable remuneration which overlaps that of the consultant. The consultant would, by the end, after eight annual rises, quite apart from distinction awards, obviously be higher than the registrar but the registrar, who would be in the forties, might well when he reaches his ceiling be still ahead of the consultant who is in his early thirties but who is without a merit award. What would you think of that?—I think the answer to your question is this: I would not be opposed to paying these people very well because I think there is a danger of them feeling that they are rather in a blind alley with nothing leading out of it. I think this would be settled much better if it came not from me but from bodies like the consultants' body of the B.M.A. and the Colleges who have worked intimately on this. You must not pay them so that you are going to work up this thing again with S.H.M.O.s all over the place so that they regard themselves as consultants. If we are going on that way, we cannot make any progress. What they are paid would be best got from these committees who can say what can safely be done without putting into their minds that they are really consultants in a few months' time. I think that is the problem.

1100. What I think was suggested is that age for age, up to a certain age there would be a sort of reducing differential between full-time salary of a consultant and full-time salary of a permanent registrar?—Exactly.

1101. You have no particular views on that?—No. I do not think I am au fait over that detail. I have not worked on it. I think there are a lot of people who have who might help you quite a lot. The problem is exciting all this old

suspicion. We must get rid of that, that the Ministry are using people to do consultant work who are not consultants. I do not think it is the Ministry at all but this suspicion is widespread and poisoning relations.

Chairman: We shall in due course be having the Ministry in front of us and I hope we will be able to give them an opportunity of saying to what extent they are using sweated labour or not.

1102. *Mrs. Baxter:* Am I right in thinking that you regard the crux of the matter as being the proper employment of a good half of these senior registrars who are stuck?—Yes.

1103. But provided they are given a title and status which is their due from ability, the other side, the chap who will never be much good, could safely be left?—Precisely. That is precisely what I do feel.

1104. *Chairman:* If you think there is a shortage of consultants in, say, surgery, if you like, is it in any one part of the country or is it all over? Is it large or little?—I do not think I have the material to answer that statistically.

1105. *Professor Jewkes:* I was just going to raise much the same point. The Commission is really in great difficulties here because if the medical profession came out flat and said there are too few consultants, as you yourself said, this simplifies the problem. If there are too few consultants let us have more and this would help to solve the senior registrar problem. But the medical profession does not speak with one voice about that. Let me give you an illustration. Recently we had the Willink Report produced and my reading is that they do not express any anxiety about numbers, and indeed, in some of the other evidence that has been put to us, there is no anxiety about numbers as you yourself have presented it.—Do you mean numbers of the profession?

1106. Yes.—I think the Willink Report was primarily concerned with the entry into medical schools.

1107. That was a cautiously worded document but my own feeling was that they were not really saying there ought to be more consultants. Unless you are prepared to admit that there ought to be more consultants on its merits then you leave yourself open to the argument that if there are too many senior registrars

as everybody believes, the right answer is to cut down on registrars and that will solve the problem. There are some people who say is not this the right way to restore the balance?—I would have thought the answer to that is that in 1951 they slashed the registrars. I do not know about the morality of all this: they led people up the garden path. They spent the best years of their life there. They are well qualified as far as degrees go and they can neither get in general practice nor consultant practice. As a matter of fact, I think the Willink Committee concentrated on the free entry into medical school and I would not have thought myself that it was at all competent to deal with purely professional questions. That is a very different matter you are now raising, the question of the supply of consultants. It is very difficult for anybody to say how many consultants are needed statistically. All you can say when you go to places and find there is no surgeon at all or when you find major surgery of the most important kind being done by the senior registrar without anybody supervising at all you begin to wonder.

1108. *Chairman*: Your only solution would be to cut down the number of senior registrars by permitting those to be consultants who are doing consultant work?—That is humane and just and I do not think it is a very expensive way.

1109. *Professor Jewkes*: That is an example of being able to kill two birds with one stone?—Yes.

1110. *Chairman*: Lord Moran, there is one point that you have not touched on yet in the notes we sent you. I do not want to keep you too long although I should imagine it would be difficult to tire you. We asked for comments on the remuneration of part-time and whole-time consultants and whether it is unduly biased against whole-timers. Do you know that we have had evidence from the Whole-time Consultants Association that implied very much that it was. On two cases, partly on taxation questions on which I do not think we need to go with you because those are questions of fact, and also very much on the question of weighting. The nine and a half pay for nine part-time sessions. Evidence was given that where people could they became part-time or nine-elevenths part-time if they could which seemed to lend some substance to what the whole-timers were submitting. Have

you any views that you would wish to put to us on this?—What is the direct question?

1111. Do you think that the present system of remuneration and particularly the system of weighting is biased against whole-timers or in favour of part-timers?—I do not think I am competent to say. I was very sympathetic to the whole-timer because I thought the income tax people were definitely differentiating against them. But I have never won a battle with the income tax yet and I never hope to. I think we did them an ill turn because in trying to help the whole-timer we also drew the attention of the income tax people to the part-timer. I was not in on this but I think that was entirely unintentional. Without benefiting the whole-timer at all they began trying to put the part-timer on another schedule and I do not think we are going to get any change from the Income Tax Commissioners. Supposing they were equally treated for taxation do they feel they have a grievance beyond that?

1112. Yes.—They do?

1113. The other point mentioned was this question of treating nine sessions as nine-and-a-half, paying for nine-and-a-half. I am wondering if you have any views about that?—No, I have not.

1114. And I think I am right in saying that somebody who is employed part-time gets the same proportion of the merit award?—That is true. I do not want to go into this whole-time thing, but the whole question of whole-time and part-time I think is terribly difficult to decide. On the one hand the experience that has always impressed me most is that of the Indian medical where men were allowed to practise. It was an extraordinarily efficient service which was never duplicated elsewhere. The Royal Commission Report of 1913 on the University of London is a tremendous document for the whole-timer. If you balance those two things together you have got something. I do not know whether you want to stop, but there is one thing I wanted to say. This Royal Commission in 1913 was very exceptional in one way: it had Moran, Milner and Haldane all on it. As expected, it was quite a classic document. The theme of their thing was that the occupants of Harley Street, Wigmore Street and Wimpole Street spent so much time in

the pursuit of gain they forgot the pursuit of knowledge. That is their thesis; I am not saying whether it is right or wrong. As a result in 1919 they produced the eight professors at £2,000 a year. All this may seem irrelevant—it will be clear in a second, and I am sure Sir David will not mind my saying a word about Vice Chancellors at this juncture because I am concerned really with the criticism of the awards. What happened with this report was they created these people—I am now speaking of 1919—the Vice Chancellors felt quite rightly that it was very nice for medicine but not at all nice for engineering, agriculture and the other faculties. There were strong representations which the Government of the day and succeeding governments have not taken notice of. When the awards came in the Vice Chancellors and their personal representatives, without waiting to see whether they were in or not, launched this thing. I am not making a controversial point. The opposition to the Awards Committee was clearly historical on the grounds of different awards to different faculties. It was nothing to do with the medical awards at all. It was a very valid point and if I had been a Vice Chancellor I should have done exactly the same thing myself. All I am pointing out is the continuity of the thing that began in 1919, whereas the awards did not come in until 1939—twenty years later—a very important point. The opposition has come from three sources. There is nothing to complain of in individual criticism. It has occurred. You are putting a very high test on a man of 58 if he sees himself passed over for a man of 38. It requires a real generosity of mind judiciously to say "this is a good system" in those circumstances, and I think the profession has come well out of it. I am surprised how well they have come out of it, so I have nothing to say. Where they had correspondence in the medical journals, fostered by the

B.M.J., there were only seven letters and four of those branched off into what the surgeon and the anaesthetist should get. One would think that if the whole profession was surging with indignation that correspondence would not have been like that. Further than that, there were votes at meeting after meeting in 1949 and 1950 without eliciting any of this opposition, so if I put the opposition under three headings—individual, British Medical Association and the Vice Chancellors—I think that is a fair way of summarising it. The B.M.A. opposition has been confined really to general practitioners and has been reversed at a meeting—a great representative meeting—and by the Council, and if you are pursuing, Sir David, that there is a historical element in this, I would rather like to end by saying this opposition is not quite as strong as has sometimes been said.

1115. *Chairman*: Thank you very much. I think I can assure you that this Royal Commission is engaged in the pursuit of knowledge. I do not know that I have any more questions I want to ask you at this moment. We may perhaps at some later date like to take the opportunity of having a further talk with you and it might be that we shall want it in private if we wish to go into individual details that it is unwise to disclose in public—but I do not know. Have any of my colleagues any further questions?

Professor Jewkes: No questions, Mr. Chairman, but if Lord Moran would be prepared to reveal to us the secret of his powers of endurance we would all be very grateful.—I am extremely grateful to you for listening. You must see, of course, that I am an enthusiast and they are always boring. If I can help at any time, Mr. Chairman, of course I shall be delighted to do so.

Chairman: Thank you very much for coming and giving us so long.

(The witness withdrew.)

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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

5—6

Fifth Day, Thursday, 23rd January, 1958

Sixth Day, Friday, 24th January, 1958

WITNESSES

British Medical Association

LONDON

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

FIFTH AND SIXTH DAYS

Thursday, 23rd January, 1958

Friday, 24th January, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MRS. K. M. C. BAXTER

MR. A. D. BONHAM-CARTER, T.D.

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

PROFESSOR JOHN JEWKES, C.B.E.

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MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

Preliminary Memorandum of Evidence presented by the British Medical Association to
The Royal Commission on Doctors' and Dentists' Remuneration, November, 1957

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I. INTRODUCTION

(1) The British Medical Association

1. The British Medical Association is a voluntary organization of over 71,000 members, all registered medical practitioners engaged in various forms of practice at home and overseas. It therefore speaks with authority for all branches of the profession.

2. The Council of the Association has of course obtained the views of those Standing Committees—the Central Consultants and Specialists Committee and the General Medical Services Committee—which have special responsibilities in the fields of hospital and general practice.

3. The Central Consultants and Specialists Committee is a Standing Committee of the Council. It is in addition the central body of a comprehensive organization representative of all consultants and hospital medical staffs. It consists of representatives of Committees set up in each of the hospital regions, which in their turn represent the senior medical staff—consultants and senior hospital medical officers—of the teaching and non-teaching hospitals in the region. It also includes representatives of registrars and of certain specialist groups, e.g., in anaesthetics, orthopaedics, radiology, etc. Thus this nation-wide organization represents some 18,000 members of hospital medical staffs working in the National Health Service.

4. The General Medical Services Committee is likewise a Standing Committee of the Council, and is also the Executive of the Annual Conference of Representatives of Local Medical Committees, which considers matters affecting all practitioners—whether members of the Association or not—providing general medical services under Part IV of the National Health Service Acts. In this way the General Medical Services Committee represents some 23,000 principals and assistants engaged in National Health Service general practice in the United Kingdom.

5. The constitution of these two Standing Committees of the Council places the Association in a unique position and enables it to speak with particular authority on behalf of all members of hospital medical staffs and all general practitioners on the matters now under review by the Royal Commission.

(2) Preliminary Statement of the Association's Views

6. The Royal Commission has on more than one occasion expressed its intention to proceed with its task as speedily as possible, and the Council is therefore anxious that a preliminary statement of the Association's views on the general issues involved should be submitted to the Commission with the least possible delay.

7. In the main, this preliminary statement outlines the history of the profession's negotiations with the Government; sets out the basis and amount of the present remuneration claim, and describes the training, duties, and responsibilities of doctors who are engaged in hospital and general practice under the National Health Service.

8. The Commission will no doubt subsequently require evidence on more detailed matters within its terms of reference, and it is the Council's intention to submit further memoranda on a number of subjects not covered by this preliminary statement. These will include more detailed evidence, for example, upon the position of junior hospital staff, senior hospital medical officers and registrars, medical superintendents, administrative medical staff of Regional Hospital Boards, ophthalmic medical practitioners, medical officers in the Public Health Service, and university teaching staff. The Council will also make known its views on that part of the Commission's remit which deals with arrangements to keep remuneration under review. Memoranda on these and other matters will be submitted by the Council with the least possible delay.

(3) The Government's Obligation to the Profession

9. The history of the remuneration dispute and the events which led to the appointment of the Royal Commission are fully set out in later sections and in the various appendices to this memorandum, but the Council wishes to place on record in this introductory section that in deciding to give evidence before the Royal Commission the profession does so without prejudice to its rights to press for the fulfilment of the Government's clear

moral obligation to honour the promises made to the profession when it entered the National Health Service on the appointed day.

10. The Council does not believe that any useful purpose would be served by indulging in recriminations, however justified, over the tactless and highhanded manner in which the Government has dealt with the profession's claim. Whatever its legal position may be, the profession's moral rights are unassailable and the Council cannot but contrast the treatment so far meted out to the medical profession with the alacrity shown by the Government in recent years in meeting its obligations to many other sections of the community—particularly those who are in a position to bring pressure to bear in support of their claims. The nature and traditions of medicine are such that the profession is reluctant to resort to measures used in other spheres in support of remuneration claims, and there can be little doubt that this fact has influenced the attitude adopted towards it. Against this background, notwithstanding its decision to give evidence to the Royal Commission, the Council must make its own attitude to the Government's definite obligations quite clear.

(4) The Royal Commission's Terms of Reference

11. The Council wishes to draw attention to the developments which have taken place since the Royal Commission was appointed on February 28, 1957, with the following terms of reference:

"To consider:

"(a) How the levels of professional remuneration from all sources now received by doctors and dentists taking any part in the National Health Service compare with the remuneration received by members of other professions, by other members of the medical and dental professions, and by people engaged in connected occupations;

"(b) What, in the light of the foregoing, should be the proper current levels of remuneration of such doctors and dentists by the National Health Service;

"(c) Whether, and if so what, arrangements should be made to keep that remuneration under review;

"And to make recommendations."

12. Firstly, the Commission itself made the following public statement on April 12, 1957:

"In view of doubts cast on the interpretation of the terms of reference, the Royal Commission have given urgent consideration to this matter, and think it may be convenient if they announce publicly how they have decided to proceed. They have shown this statement to the sponsoring Ministers, and they understand that it is wholly consistent with the intentions formed by the Government when advising the appointment of the Royal Commission.

"1. The Spens Reports and the Danckwerts Award will be studied by the Commission, and also the Reports of any other Commissions and Committees in so far as they are relevant to the circumstances of the medical and dental professions and to the relationship of those professions to the community as a whole.

"2. The Commission will bear in mind the need for maintaining a proper level of recruitment to the medical and dental professions in competition with other callings, and will consider evidence as to conditions imposed by the nature of the work.

"3. The phrase 'other professions' will be interpreted widely so as not to exclude, for example, science and other graduates in industry at all levels.

"4. The Commission are not asked to recommend remuneration for doctors and dentists employed by local authorities; but these doctors and dentists are among the 'other members of the medical and dental professions' on whose remuneration evidence will be received for purposes of comparison.

"5. 'Other connected occupations' cover a wide range of persons, including on the one hand hospital administrators, and on the other, nurses and medical auxiliaries, whose remuneration will be considered with special reference to differentials.

- " 6. The Commission will in the light of all this and any other relevant evidence recommend such 'current levels of remuneration' as appear to the Commission to be justified.
- " 7. The Commission's duty to recommend current levels of remuneration calls for recommendations covering, for example, average incomes and the desirable spread between extremes; but it does not call for the construction of detailed schemes of distribution.
- " 8. After consideration of the desirable current levels of remuneration for doctors and dentists, the Commission will consider whether, and if so what, arrangements should be made to keep that remuneration under review.

" In a separate notice the Royal Commission are asking all interested persons or organizations to offer evidence. Preliminary enquiries have shown that the preparation of this evidence will take some of the bodies concerned considerable time. The Commission are anxious to complete their task with the utmost speed consistent with thorough examination of all the relevant issues, and hope that all written evidence and submissions to the Commission will be in their hands within the next three months."

Secondly, on April 23, 1957, the Chairman of the Commission offered the following additional statement:

" That part of the Royal Commission's task that consists of considering what should be the proper current levels of remuneration of Doctors and Dentists will include hearing submissions from those professions as to the remuneration which they are now claiming."

Thirdly, the following exchange of letters took place as the result of an interview between the Chairman of Council of the Association and the Minister of Health on April 26:

" Dear Mr. Vosper,

" Dr. Wand asks me to say that he will be extremely grateful if you can find it possible to send him a letter by hand to-day, addressed to B.M.A. House, to confirm the assurance you gave him yesterday afternoon, which I understand was in the following terms:

" ' Following the Report of the Royal Commission there will be full consultation with the profession before implementation of any of its findings, such consultation to include any other matters relevant to the Report or to the present dispute.'

" Dr. Wand would be grateful also if you could now assure him that the terms of the Public Statement issued by the Royal Commission will be regarded as prevailing over the Terms of Reference as originally drafted.

" Finally, Dr. Wand would greatly appreciate any observations you may be able to offer as a result of your further consideration of the position of the Public Health medical officers in relation to the Royal Commission."

" Dear Dr. Wand,

" I was glad of the opportunity of a long talk with you yesterday and I hope you feel—as I do—that it is that kind of informal and personal discussion which does most to clear away misunderstandings.

" First, let me confirm what I said to you when I assured you that, following the report of the Royal Commission, there will be full consultation with the profession before implementation of any of its findings and that such consultation could of course include any matters relevant to the report or the present dispute.

" Second, you seemed to fear some inconsistency between the terms of reference of the Commission and the public statements issued by its Chairman. I can certainly reassure you here too. It is normal that the interpretation of the terms of reference of a Royal Commission should be a matter for its Chairman and the Commission, and you can certainly regard the public statements which have been issued as having full validity.

" Finally, I have thought—as you asked—about the position of the public health medical officers. I cannot add anything of substance to what I said in my letter of

17th April on this, but let me repeat that I am sure that any settlement for others, following the Commission's report, could not fail to be taken into account in considering the position of these officers and any claim through the normal machinery would of necessity be considered in the light of the report and of any settlement subsequent to it.

"I do hope that these remarks, and our talk yesterday, will help to rid us of unnecessary apprehensions."

13. The Council still maintains that the dispute on remuneration ought to have been settled by the accepted methods of negotiation and arbitration. This is by no means the first occasion upon which the Government and the profession have been in dispute on levels of remuneration from public sources. Since the inception of the National Health Insurance scheme in 1911, there have been repeated disagreements on levels of remuneration, and in 1946 the first of the two Spens Committees was set up to determine what should be the proper remuneration of general practitioners in a nationally organized service. The Spens Committee corroborated the profession's view that for National Insurance patients general practitioners had been seriously underpaid for very many years, and in point of fact this underpayment has never been made good. In 1952 the Dankwerts Adjudication endorsed the profession's claim for a substantial increase in remuneration to implement the Spens recommendations, and in this instance made the proper adjustment for the underpaid years of the new comprehensive Service. As will be shown later a similar disagreement occurred after the publication of the Spens Report for hospital medical staffs in 1948 and also before certain adjustments were made in 1954.

14. In the case of the present claim, however, the Government refused either to negotiate or refer the matter to arbitration, and the Council therefore takes the view that the dispute can only be satisfactorily resolved by the Commission if its recommendations are determined in the light of all that has happened in the past, particularly the Government's promises to the profession following the publication of the Spens Reports. This view would seem to be supported by the Commission's interpretation of its remit as set out above.

15. Later sections of this memorandum set out in detail the circumstances in which the profession agreed to take part in the National Health Service.

16. It must, however, be stressed that a proper implementation of the Spens Reports is fundamental to the Association's case. It was the Government's decision to set up the Spens Committees. The profession warmly supported this decision and accepted the principles and recommendations of the two Reports, has continued to stand by them, and sees no reason to depart from them. Nor must it be overlooked that in the case of general practitioners the Permanent Secretary to the Ministry of Health in a letter addressed to the Association on May 2, 1950, stated:

"The Minister agrees that the Spens Report remains the basis of the remuneration of general medical practitioners until such time as after the usual consultations some other basis is substituted."

This statement makes it clear that until some other basis is agreed with the profession the Spens principles must stand.

17. Indeed the principles laid down by the two Spens Reports were a sheet anchor for the profession in the difficult transition from private to public practice inasmuch as—after a thorough review—they determined what should be the proper "social and economic status" of the medical profession *in the community as a whole*. Had there been no National Health Service individual members of the profession would have kept their place in the community by the normal practice still open to other self-employed persons, namely, by adjusting fees and prices to meet the altered circumstances brought about by changes in the value of money. The certainty that this method of adjustment would not be possible in a public service was clearly in the minds of those who drafted the General Practitioner and Consultant Spens Reports, and was the reason for their recommendation (Paras. 6 and 2 respectively) that their findings would fail to maintain the status of and recruitment to the medical profession unless adjustments were made from time to time to meet changing conditions. The Government for its part accepted the Spens principles and has at no time advanced any convincing reason for discarding them. True, it has disputed the amount of the adjustment required in an inflationary era, and so far as the Council is concerned that is the only matter now in dispute.

18. The Council therefore submits that any radical departure from the principles laid down by the Spens Committees would be a breach of the undertaking given by the Government and would remove the only safeguards open to the profession whereby its status and powers of recruitment can be ensured.

19. The Council, having made its position quite clear on these major questions of principle, recognizes that the Commission will need to have the fullest possible account of the events which have led up to the present situation. The following paragraphs and appendices to this memorandum set out the history of the Association's dealings with the Ministry on remuneration and elaborate the arguments in favour of maintaining the place of the medical profession *vis-à-vis* the community as a whole.

II. PAST HISTORY—THE SPENS REPORTS AND PRESENT LEVELS OF REMUNERATION

20. In order that the present dispute may be judged objectively it is necessary to go back in history to the points at which the present agreed bases of remuneration in the two fields emerged—the Reports of the Spens Committees on the remuneration of consultants and specialists and on the remuneration of general practitioners. Although both general practitioners and hospital medical staffs are now on common ground in their approach to the problem, up to 1956 these two branches of the profession negotiated with the Government independently of each other, and levels of remuneration in each field developed quite separately. This was perhaps inevitable, for they emanated from two separate sets of recommendations which were published independently and at an interval of two years. Moreover, different channels of negotiation existed in the two fields of practice. This section of the Council's memorandum is therefore devoted to an account of the negotiations which took place in each field prior to 1956 to secure the implementation of the recommendations of the two Spens Committees.

(A) GENERAL PRACTITIONERS

(1) The General Practitioner Spens Committee

21. The proposals for a comprehensive National Health Service carried with them many implications for general practitioners, who had hitherto practised medicine mainly free of Government control and who were then, in common with all other professions, free to seek their own level of remuneration by arrangement with the individual patient. True, there existed the old National Health Insurance Scheme, but this catered for less than half of the population and provided considerably less than half of the general practitioners' total income. For the most part, remuneration did not depend upon public funds.

22. The establishment of a National Health Service and the acceptance of the principle of collective responsibility have virtually led to a State monopoly of general medical practice, and the opportunities for practice outside the Service have now become almost negligible. Indeed, the fact that almost the whole population have now signed on the lists of general practitioners in the National Health Service is proof not only of the way in which general practitioners have fulfilled their part of the contract and of the value of their services, but of the complete dependence of the profession on the Government, which has a clear duty to ensure that doctors do not suffer financially just because their opportunities outside the Service are now so few. All this was envisaged by the Association during the discussions with the Government preceding the Appointed Day, when it was agreed that there must be some equitable basis upon which doctors could participate in the National Health Service. Furthermore, there was a vital need to ensure that the Service would continue to attract a sufficient number of recruits of the right calibre to its ranks.

23. There was no lack of encouragement on the part of the profession to a comprehensive health service. Indeed, the need has been stressed by the Association on many occasions and the views of its Medical Planning Commission were quoted by Lord (then Sir William) Beveridge in his report in 1942 as being in accord with his own assumption that a comprehensive health service would be an integral part of any scheme of social security. Nevertheless, remuneration apart, many important principles were involved

in the transition from private to public practice, and general practitioners had to be mindful both of the interests of their patients and of their own future when the new scheme was being evolved.

24. From their own viewpoint general practitioners welcomed the Government's decision to set up a Committee under the Chairmanship of Sir Will Spens with the following terms of reference:

"To consider, after obtaining whatever information and evidence it thinks fit, what ought to be the range of total professional income of a registered medical practitioner in any publicly organized service of general medical practice; to consider this with due regard to what have been the normal financial expectations of general medical practice in the past, and to the desirability of maintaining in the future the proper social and economic status of general medical practice and its power to attract a suitable type of recruit to the profession; and to make recommendations."

25. The profession gave its wholehearted support and co-operation to the General Practitioner Spens Committee which reported in 1946 (the report is set out in *Appendix I*) and its recommendations were accepted without reservation by both the profession and the Government. The latter, in addition to public statements, wrote to the Association on July 22, 1946, in the following terms:

"The Minister desires to make his attitude to the Spens Report quite clear. He fully accepts the substance of the recommendations upon the general scope and range of remuneration which general practitioners should enjoy in a public service."

26. *It was on the basis of this clear assurance that general practitioners agreed to enter the National Health Service on July 5, 1948.*

(2) Implementation of the General Practitioner Spens Report

27. Once agreement had been reached on the basic principles upon which general practitioners were to be remunerated in the National Health Service, it became necessary first to translate those principles into terms of the global sum of money necessary to give effect to them, and, second, to calculate the amount which should be added to that global sum to take account of the fall in the value of money and the increases which had taken place in the remuneration of other professions since 1939.

28. The first task did not prove difficult. With the co-operation of the Government the necessary calculations were made and agreement reached that the required sum to give effect to the Spens recommendations in terms of the 1939 value of money and in respect of the 17,900 principals in general practice in 1939 was £19·89m., plus £11·35m. for practice expenses, making a total of £31·24m.

29. The second task, however, led to a protracted dispute upon the correct adjustment to be made in the light of the following paragraph (para. 6) of the Spens Report:

"We leave to others the problem of the necessary adjustment to present conditions, but we would observe in this connexion that such adjustment should have direct regard not only to estimates of the changes in the value of money but to the increases which have in fact taken place since 1939 in incomes in other professions. In our judgment it is only if corresponding changes are made in the incomes of general practitioners that the recruitment and status of their profession will be maintained as against these professions."

30. Eventually, the Ministry proceeded to make various *arbitrary* adjustments to the agreed global sum. In particular, in what it alleged to be in conformity with the Spens recommendations, it imposed an arbitrary betterment factor which the Danckwerts Award subsequently proved to be grossly inadequate.

31. The Council maintained from the start that the Government's method of calculating the global total of general practitioner remuneration could not implement the Spens recommendations. The betterment factor arbitrarily applied was obviously much too low, having regard to both changes in the value of money and the increases which had taken place in the incomes of other professions. Furthermore, in the year 1948-49, 18,812 doctors were being asked to share the adjusted remuneration applicable to 17,900 general practitioners pre-war. In spite of this, subsequent negotiations with the Ministry of Health proved completely abortive.

32. It is pertinent at this stage to draw attention to yet another assurance of the Government's intention to implement the Spens recommendations, for in the House of Commons on January 21, 1949, the Parliamentary Secretary to the Ministry of Health said:

"I say to the House quite seriously that when the final payments for the period July 5 last to March 31, 1949, have been made we shall then be able to see whether the remuneration of general practitioners does, in fact, accord with the Spens recommendations. If it does not, the arrangements will be reviewed to see what adjustments are necessary to give effect to those recommendations."

(3) The Danckwerts Adjudication

33. Finally, after some four years of fruitless discussion had failed to produce any offer of a reasonable settlement, the Ministers agreed to the submission of the dispute to an independent arbitrator. Mr. Justice Danckwerts accepted this appointment and his terms of reference, agreed by both parties, were as follows:

"To determine the size of the Central Pool, after taking account of remuneration from all other sources received by general practitioners, in order to give effect to the recommendations of the Spens Committee, having regard to the change in the value of money since 1939, to the increases which have taken place in incomes in other professions and to all other relevant factors."

34. Once again the Government reiterated their acceptance of the Spens recommendations as the basis of general practitioner remuneration in the National Health Service.

35. The Statement of Case submitted to the Adjudicator by the General Medical Services Committee of the Association is set out in *Appendix II*. This document sets out in detail the questions then in dispute which were not the Spens recommendations themselves but merely the method by which the Government had decided to implement them. It also provides a full history of events to that time.

36. The results of the adjudication justified the contentions which the Association had made in the course of its long and stultifying negotiations with the Government.

37. On every important issue the adjudicator found in the profession's favour.

38. He established two vital principles, (1) that the Central Pool was to be adjusted in relation to the number of doctors in the service each year, and (2) that differential betterment factors for the years in question far in excess of the Ministry's arbitrary figure were to operate. In the financial years 1948-49 and 1949-50 the betterment factor was to be 85 per cent and for the financial year 1950-51 it was to be 100 per cent.

39. These principles which were so clearly established in the profession's favour provide judicial proof of the intentions underlying paragraph 6 of the Spens Report.

40. The amount due to the profession, including arrears for the period July 5, 1948, to March 31, 1952, alone amounted to over £39m. The magnitude of the sum itself illustrates the extent of the injustice which had been perpetrated since the National Health Service came into being. The actual award made by Mr. Justice Danckwerts on March 24, 1952, is set out in *Appendix III*.

(4) The Working Party on the Distribution of the Pool

41. To complete this account of events at that time, it must be emphasized that although the recommendations of the Spens Committee were concerned both with the size of professional incomes to be shared by general practitioners in a publicly organized Health Service and with the spread of those incomes over the range of general practitioners engaged in the Service, Mr. Justice Danckwerts was asked to adjudicate only on the total sum required to give effect to the recommendations and not with the manner in which that total sum should be distributed among the individual practitioners or the various categories of practitioners indicated in the Spens Report.

42. The distribution of the new total sum available was, at the Government's insistence, the subject of an independent and separate enquiry, undertaken by a Working Party consisting of representatives of the Ministry of Health, the Secretary of State for Scotland, and the General Medical Services Committee of the Association.

43. Both the Ministry and the General Medical Services Committee agreed that the determination of the total sum required to give effect to the Spens recommendations was a matter which should be kept separate and distinct from the question as to how that

total sum was to be distributed among the general practitioners concerned. This is borne out by the agreed terms of reference of the Working Party, viz.:

"To secure an equitable distribution of the Central Pool based upon the recommendations of the Spens Committee, the object being to enable the best possible medical service to be available to the public, and to safeguard the standard of medical service by discouraging unduly large lists; at the same time, to bring about a relative improvement in the position of those practitioners least favourably placed under the present plan of distribution, to make it easier for new doctors to enter practice, and to stimulate group practice."

44. The Working Party's report is set out in *Appendix IV* and forms the present agreed basis of distributing the existing Central Pool.

(B) HOSPITAL MEDICAL STAFFS

(1) The Consultant Spens Committee

45. Before the introduction of the National Health Service in 1948 consultants (apart from the relatively small number employed in local authority hospitals) received no remuneration from their hospital authorities, and depended for their professional income upon the fees from private practice.

46. With the decision to introduce a "free" hospital service, which would to a large extent remove the consultant's source of income, it was necessary to find a satisfactory basis for their remuneration in the National Health Service. In 1947 the Government set up a Committee, under the chairmanship of Sir Will Spens, with the following terms of reference:

"To consider, after obtaining whatever information and evidence we thought fit, what ought to be the range of total professional remuneration of registered medical practitioners engaged in the different branches of consultant or specialist practice in any publicly organized hospital and specialist service; to consider this with due regard to what have been the financial expectations of consultant and specialist practice in the past, to the financial expectations in other branches of medical practice, to the necessary post-graduate training and qualifications required and to the desirability of maintaining the proper social and economic status of specialist practice and its power to attract a suitable type of recruit, having regard to other forms of medical practice; and to make recommendations."

47. It was clear that the establishment of a National Health Service and the acquisition by the State of the overwhelming majority of hospitals throughout the country would lead virtually to a State monopoly of hospital practice, and the evidence given to the Spens Committee of the range of consultant income in 1938-39 stressed that the financial position of the hospital doctor in the future should be determined largely in relation to the position in the community he had attained under conditions of private enterprise. It was pointed out that if sight were to be lost of this important consideration it was likely to turn the attention of suitable entrants to other careers where financial reward is still dependent on personal effort and not subject to political considerations or to Government bargaining. Consultants gave their whole-hearted support and co-operation to the Consultant Spens Committee which reported in 1948 (the Report is set out in *Appendix V*).

48. The recommendations of the Consultant Spens Committee were accepted by both hospital medical staffs and the Government. The then Minister of Health (Mr. Bevan) stated in the House of Commons on June 3, 1948:

"The Report will be available to Honourable Members, I hope, to-morrow afternoon. I should like to add that the Government accept the recommendations in principle. . . ."

(2) The Implementation of the Consultant Spens Report

49. The Consultant Spens Committee, like the General Practitioner Spens Committee, framed its recommendations in terms of the 1939 value of money, and its intentions for the future were clearly set out in the following extract from their Report:

"We leave to others the problem of the necessary adjustments to present-day values of money, but we desire to emphasize as strongly as possible that such adjust-

ments should have direct regard not only to estimates of the change in the value of money but to the increases which have in fact taken place since 1939 in incomes both in the medical and in other professions. In our judgment it is only if corresponding changes are made in the incomes of consultants and specialists that the recruitment and status of the various branches of specialist practice will be maintained."

50. Since the Consultant Spens Committee completed its task in 1948, only a few months before the introduction of the National Health Service, it followed that there was no opportunity of negotiating terms and conditions of service for hospital medical staffs before the Service began. Hospital medical staffs therefore entered the Service on interim terms, relying on the assurance of the Government that it had accepted the Spens Report in principle and in the expectation that the Spens proposals would be implemented retrospectively and adjusted by the addition of an adequate betterment factor. In the meantime, the Joint Consultants Committee (a Committee established in 1948 by agreement between the Royal Colleges, the Scottish Corporations, and the British Medical Association to enable negotiations with the Government on matters affecting the hospital and consultant services to be conducted by one professional body) and the Ministry of Health had embarked upon a series of discussions on draft terms of service offered by the department in the light of the Spens Report.

51. The Spens Committee recommended that there should be a basic incremental scale for consultants ranging from £1,500 to £2,500, and that in addition individual merit should be rewarded by means of special distinction awards. These awards of £500, £1,500, and £2,500 per annum were to be granted by the Minister on the advice of a national committee of doctors and laymen, 20 per cent of consultants receiving the lowest award, 10 per cent the second award, and 4 per cent the highest award. All these recommendations were made in terms of 1939 values of money.

52. During 1948 and the early part of 1949 the Joint Consultants Committee was in dispute with the Ministry on a number of fundamental issues and did not feel able to advise consultants to enter into permanent contracts with their employing authorities. In July, 1949 the Ministry, intending no doubt to bring matters to a head, wrote to the Joint Consultants Committee in the following terms:

"You will appreciate the impossibility of a situation in which consultants and specialists are continuing to be advised to postpone entering into contracts, while being assured by us that any solution will be retrospective for them. This is an aspect that we shall be bound sooner or later to review and we want you to help us to make any such review unnecessary by joining us in speeding the solution."

53. The Joint Consultants Committee thereupon sought and obtained a number of assurances from the Ministry which it was hoped would give a measure of protection to consultants in the future, and subsequently felt able to advise hospital staffs to enter into permanent contracts based upon the Terms of Service.

54. The terms offered by the Ministry in 1949 were approximately 20 per cent above the incremental scale, but no betterment was attached to Merit Awards, which remained unaltered at the 1939 figure recommended by the Spens Committee. But worse was to come in 1954, for, as will be shown later, when hospital medical staff salaries were increased in that year a downward adjustment was made in the basic salary of consultants holding the highest or second merit awards, so that in effect these consultants suffered a reduction of £300 and £200 respectively in the value of these two awards. This inequity was increased still further in 1957 as the 5 per cent interim payment for consultants did not apply to merit awards.

55. The Council is wholly opposed to this levelling down of the income of the most able members of the consultant profession, being of the opinion that the outstanding attainments and value to the community of this comparatively small group of consultants should be reflected in a high order of remuneration as in other walks of life.

56. Moreover, the Council believes that the special distinction awards system is an appropriate method of rewarding the more able members of the consultant section of the profession and of ensuring that a significant minority have an opportunity to earn incomes comparable with the highest which can be earned in other professions. Only in this way can the best possible recruits be attracted to consultant practice, and in the Council's view such a method is indeed necessary as an incentive to efficiency. The

attachment of higher salaries to specific hospital posts would not be a satisfactory alternative. It would create a false distinction between the work of different hospitals, and would tend to operate against the policy of the Government, and of the profession, to promote the establishment of a consultant service of equal standard throughout the country.

57. It must be emphasized that, at no time, did consultants accept the 20 per cent betterment factor arbitrarily imposed by the Ministry as implementing the Consultant Spens Report. The Government would not agree that in the Whitley machinery either party could go to arbitration without the consent of the other. This refusal has been continued to the present day. Consultants, therefore, have throughout had no right to arbitration on the implementation of the Consultant Spens recommendations, and, in common with the general practitioners at that time, they had no opportunity of contesting the Government's decision to impose an inadequate betterment factor.

(3) The 1954 Award to Hospital Medical Staffs

58. Subsequently, in 1952, after the Danckwerts Adjudication had established that in the general practitioner field the betterment factor for the year 1950-51 should be at the level of 100 per cent over 1939, the Staff Side of Committee B of the Medical Whitley Council lodged a claim for a similar betterment for hospital medical staffs. It was, however, rejected by the Government, who once again refused to submit the claim to arbitration. Indeed it was not until 1954 that the Government decided to make an award to hospital medical staffs which had as its object a settlement of limited application, i.e., that of protecting recruitment to the hospital service and of restoring to a limited extent, although not in precise terms of betterment, the balance between consultant and general practitioner remuneration which had been disturbed by the Danckwerts Award. Details of the 1954 Award for hospital medical staffs are set out in *Appendix VI*.

(C) CONCLUSION

59. This historical survey of the profession's past negotiations with the Government shows—beyond all doubt—that both sections of the profession joined the National Health Service in 1948 on the basis of assurances by the Government that their future remuneration would be in accord with the principles set out in the two Spens Reports.

60. It also places on record that the Government since it assumed responsibility for almost the whole of the profession's total remuneration has been reluctant to discharge its moral obligations, and such adjustments as have been made have only followed lengthy and bitter arguments and in one case a judicial arbitration. It is therefore not surprising that the Government's conduct over remuneration in the past has left the profession with little confidence in it as an "employer."

III. THE PRESENT REMUNERATION CLAIM

(1) The 1956 Claim

61. With the settlement of these outstanding differences by Mr. Justice Danckwerts, and in the case of hospital medical staffs, but to a lesser extent, the 1954 Award, the profession looked forward to a period of financial stability and the continued fulfilment of the terms upon which it entered the Service. Unfortunately as time went on and inflation progressed, it became increasingly obvious that neither the 100 per cent betterment factor established by Mr. Justice Danckwerts nor the 1954 adjustment for hospital medical staffs were any longer sufficient to give effect to the Spens recommendations.

62. The Spens betterment factor depended upon two separate issues—variations in the value of money and the extent to which the remuneration of other professions had increased—and it became increasingly apparent to the profession that there had been substantial changes in both fields since the Adjudicator determined the issue in 1952, and that an overall increase in the size of the Central Pool and a corresponding adjustment in the remuneration of hospital medical staffs was necessary.

63. Some five years later the profession found itself in a situation where the value of its remuneration was again substantially below the standards laid down in the Spens reports. During these difficult years the profession had been reluctant, in view of the national situation, to press its case, but by January, 1956, it felt compelled to seek an

adjustment in remuneration to enable doctors to keep abreast of the steep and continuing rise in the cost of living since April, 1951.

64. The Minister of Health was so informed on February 4, 1956, and a precise claim was submitted to the Ministry of Health on June 14 in that year (see *Appendix VII*).

65. Subsequently, following discussions with Ministers and at the Ministers' invitation, a supplementary memorandum was submitted on September 12, 1956, amplifying certain aspects of the claim (see *Appendix VIII*).

66. These documents set out the grounds for the profession's claim for an increase of not less than 24 per cent in the Central Pool and in the remuneration of hospital medical staffs as at June, 1956. They also explain that, in claiming such an adjustment, the profession is doing no more than to seek the fulfilment of the Government's promises made to the profession when it agreed to enter the National Health Service in 1948.

67. Subsequent developments have not altered the Association's view that these obligations remain binding upon the Government.

(2) The Claim over the Period 1951-1957

68. The main burden of the evidence is already available in the carefully reasoned documents submitted to Ministers in June and September last year. These documents, however, show the extent of the claim only up to April, 1956, and need revision in the light of subsequent developments which have still further worsened the profession's economic position. The following paragraphs (prepared by Professor R. G. D. Allen, C.B.E., M.A., D.Sc.(Econ.), Professor of Statistics in the University of London) bring the position up to date and set out concisely the present claim in terms of the percentage increases necessary in professional remuneration year by year from April, 1951, to October, 1957.

69. The changes which have taken place in the value of money over this period are best shown in reciprocal form, as increases in the price level as measured by the index number of market prices for all consumers calculated by the Central Statistical Office. The figures shown below are taken from the 1957 Blue Book on National Income and Expenditure. Since the index is only computed for calendar years, figures for months are to be obtained by interpolation and extrapolation by use of the Ministry of Labour index of retail prices.

Period	Price Index 1948 = 100	Percentage Increase from April 1, 1951
Average 1950	105.9	
April 1 1951.....	111.0	
Average 1951	114.6	3.2
1952	121.2	9.2
1953	123.7	11.4
1954	126.0	13.5
1955	130.3	17.4
1956	136.2	22.7
April, 1957.....	139.5	27.7
July, 1957.....	142.3	
October, 1957.....	143.2	

70. The percentage increases in prices from April 1, 1951, can now be expressed for financial years, by simple interpolation between calendar years:

Financial Year	Percentage Increase in Prices from April 1, 1951
1951-52	4.7
1952-53	9.8
1953-54	11.9
1954-55	14.5
1955-56	18.7
1956-57	24.0
1957-58	29.0*

* Based on price index for October, 1957.

71. This set of figures represents the Council's claim, i.e., the percentage increases in remuneration, year by year, required to give effect to the Spens recommendation on the decline in the value of money. In the first year (1951-52) following that covered by the Danckwerts award, remuneration should have been increased by nearly 5 per cent to compensate for the decline in the value of money. This figure increases as shown until, in the current year (1957-58), the necessary increase is 29 per cent.

72. Thus at the present time an increase of 29 per cent* is required to give effect to the recommendations of the Spens Reports. In addition the profession can equitably claim that the considerable underpayment of past years should now be made good.

73. A further memorandum by Professor Allen showing the changes which have occurred in the distribution of higher incomes over the period concerned appears in *Appendix IX*. This illustrates the Council's contention that there have been considerable changes in the distribution of higher incomes during the period now under review.

(3) The Doctors' Contribution to the National Economy

74. All the arguments so far adduced merely show the extent to which the profession's relative position in society has fallen short of the standards applicable in 1948 and ignore any changes which have taken place in the economic position of the community as a whole.

75. It is common knowledge that the standard of living of many sections of the community has undergone a considerable upward change in the post-war years. The extent of this movement can best be measured by reference to the Government's own statistical evaluation of the increase which has taken place in the national income over the period concerned—the accepted method of computing changes in the community's economic well-being.

76. The following figures are from the 1957 Blue Book on National Income and Expenditure:

Gross Domestic Product, United Kingdom

	1949	1950	1951	1952	1953	1954	1955	1956
<i>Aggregate Product</i>				1948 = 100				
By value (current factor cost)	107.0	111.0	123.5	136.0	144.8	153.9	163.6	176.2
By volume (1948 factor cost)	104.4	107.4	112.0	112.3	116.9	121.8	125.9	127.6
Working population† ...	100.0	100.8	102.0	102.3	102.6	103.9	105.0	105.8
<i>Product per head</i>								
By value (current factor cost)	107.0	110.2	121.1	133.0	141.2	148.2	155.9	166.5
By volume (1948 factor cost)	104.4	106.6	109.8	109.9	113.9	117.2	119.9	120.6

† Including armed forces and unemployed; Ministry of Labour data.

77. Thus the national product has risen, between 1948 and 1956, by 76.2 per cent in money value and by 27.6 per cent in real terms. This is far greater than the increase in population, so that, on a per-head basis, the rise is 66.5 per cent in money and 20.6 per cent in real terms. The medical profession has a right to expect a share of this increase, not only from the point of view of their relative standard of living as members of the community, but also because they have made their contribution to the increased productivity responsible for the rising national income. In fact, since the Danckwerts Award for 1950-51 (and the 1954 adjustment for hospital medical staffs), their rewards have been unchanged in money and have declined considerably in real terms. While the standard of living of the community has been rising, that of the medical profession has been subject to a continuing fall.

* N.B.—Throughout this document figures relating to both the profession's claim and present levels of remuneration ignore the interim payments made by the Government earlier this year and require modification to that extent.

78. On a wider view, the whole National Health Service has been squeezed year by year. The Guillebaud Committee, in paragraphs 20-23 of their Report (Cmd. 9663, January, 1956), provide all the evidence necessary on this point. This is up to the time of that Committee's investigations (1953-54), and the position has not changed much since then.

Net Cost of the National Health Service, England and Wales

	1949-50	1950-51	1951-52	1952-53	1953-54
Net cost of N.H.S. (current prices) £ million	371.6	390.5	402.1	416.9	430.3
Percentage of gross national product ...	3.75	3.71	3.48	3.34	3.24
Net cost of N.H.S. (1948-49 prices) ...	369.8	388.3	374.1	370.6	380.8

79. The Guillebaud Committee concludes that "the widespread popular belief that there has been an increase of vast proportions in both the money cost and the real cost of the National Health Service is not borne out by the figures."

80. The cost of the National Health Service has not therefore expanded with the growth of economic activity, or with rising prices, in the community as a whole. This is in terms of cost; it does not imply that the medical needs of the expanding economy are failing to be met.

81. Certainly the rewards of those employed in the National Health Service have been kept down, though some (e.g., nurses and domestic staffs in hospitals) have been awarded higher rates of pay. In the squeeze of the National Health Service the main impact has been on the medical practitioners themselves.

82. Claims for higher pay by various groups are as often based on increases in productivity of the groups as on falls in their living standards occasioned by rising prices. For members of the medical profession the fall in standards of living is obvious enough. Something needs to be said about their "productivity," on the contention that doctors make a substantial contribution to the rising national income.

83. The contribution of the medical profession to the national product (as indeed that of the National Health Service as a whole) can be viewed in two ways. First, doctors can be regarded as providing a direct service to the public. There is no doubt that in a free economy the public would be willing to pay more for their doctor's services out of higher incomes. As it is, this exercise of consumers' preferences is blurred by the fact that the overwhelming majority of the population make use of the National Health Service. It therefore follows that doctors are entirely dependent upon the Government in that they are unable to adjust their fees to bring them into line with new conditions and thus participate in the rising national income. This is manifestly unfair if only because the higher incomes which flow from increased productivity result in a higher tax yield which could be made available to reward the doctor for the part he has played in making the increased productivity possible.

84. Secondly, the medical services can be regarded as an important factor of production, like the services of entrepreneurs or skilled workers. Doctors maintain and improve the health and efficiency of the working labour force, both in the factories and outside in doctors' surgeries and in hospitals. Moreover, the Health Service is an investment, like workers' training or plant and machinery, leading to increased productivity in the future; this is particularly so in respect of the improvement in the health of children.

85. It is possible to measure increases in the productivity of, say, engineers or ship-builders, though not easy to decide whether they are due to more skill in working or to the provision of better equipment to work with. In any case, whenever productivity rises, the workers concerned have come to expect to be rewarded with higher pay. The "productivity" of doctors, however important it may be, is not easy to assess, still less to measure in precise terms. Indeed, in contradistinction to the examples quoted above, although doctors now have the advantages of more modern equipment and powerful therapeutic agents their "productivity" still depends mainly upon the efforts of the individual doctor himself. There can be no doubt that advances in medical knowledge and

practice have taken place, with a consequent improvement in the health of the community. Medical research and the skill of doctors has undoubtedly resulted in the higher expectation of life and relative freedom from epidemics, and these are positive assets to the country, tending to raise its productive capacity.

86. The effect of the doctor's work is therefore to be seen, not only in comfort given to the sick, but also as a direct contribution to higher productivity of the country's labour force, and the Council submits that the medical profession has every right to participate in the benefits which are now enjoyed by other sections of the community.

(4) Other Aspects of the Remuneration Claim:

(a) *Comparison with other Professions and Occupations*

87. All that has been said so far relates to the more factual aspects of the remuneration dispute, and the Council submits that these in themselves are quite sufficient to establish its view that a substantial increase in remuneration is urgently necessary both as a matter of justice and to safeguard the future status of the medical profession.

88. The original terms of reference of the Royal Commission required it to compare the remuneration of doctors in the National Health Service with the remuneration of other professions and of people engaged in connected occupations.

89. The Council wishes to record its view that such a narrow determination of the claim would be in direct conflict with the principles agreed by the Government when the profession entered the National Health Service. The recommendations of the Spens Committees were determined not on the basis of a narrow comparison with other professions but on a basis of free enterprise and competitive economy. They placed the medical profession in its proper relative place in the community and it is on this basis that its remuneration should still be assessed.

90. Indeed, the phraseology of paragraphs 6 and 2 respectively of the General Practitioner and Consultant Spens Reports which referred to *increases* in other professions and the association of those increases with recruitment and status obviously by the use of the word "increases" intended that

- (1) The medical profession should maintain its status in the general community;
- (2) The medical profession should not be outpaced in competition for its proper share of the best recruits.

91. It would be quite wrong to interpret the word "increases" as equivalent to the word "changes". The intention of the Spens Committees was not that the remuneration of doctors in the future should be compared with the earnings of other professions, but that their place in the community and the ability of the profession to attract recruits of a suitable calibre should not be impaired by increases taking place in the incomes of other professions still operating in a competitive market.

(b) *Medical Training and its Bearing on Remuneration*

92. Another important factor to which the Council wishes to refer is the nature and length of the doctor's training. This factor is, for a number of reasons, closely bound up with future levels of remuneration in the medical profession.

93. First, the Spens Committee referred to the length of a doctor's training as one of the main reasons for their recommendations on the financial rewards of medical practice. The same arguments hold good to-day—indeed, they are strengthened by the increase which has taken place in the length of medical education.

94. Second, in any profession or occupation earning power must continue to reflect the length and nature of training, or recruitment is bound to suffer.

95. Third, if the Commission in pursuance of its terms of reference seeks to compare the remuneration of the medical profession with that of other professions and connected occupations this question is paramount.

96. In all professions, the period of training is lengthy by comparison with most other walks of life. This is particularly so in medicine, where the *minimum* period of training is now six years. In some cases the full period of training is undertaken in the medical school. In others the boy remains after the normal leaving age and takes his pre-medical

subjects at school before commencing upon 5 years' minimum undergraduate training. Normally full training takes seven years. In addition, there is one year's compulsory hospital work (which in practice often extends to 18 months or more) before full registration is achieved and the newly qualified doctor can commence upon his chosen career. In fact, this period is normally lengthened by the holding of further junior appointments in the hospital service before the young doctor is in a position to decide upon the field in which to make his permanent career.

97. The Council has already expressed its view that a simple comparison between the earnings of doctors and the remuneration enjoyed by other "comparable" professions would be fallacious and contrary to the principles laid down by the Spens Reports. In the Council's view it is far more important that if comparison must be made it should be made in relation to the community as a whole—quite apart from the obvious difficulties of deciding what is or is not a "comparable profession". In many professions the new entrant is remunerated whilst he is learning his job and studying for his qualifying examination. No exact data are available to show the average age at which provisional registration is achieved, but from information received it appears to be 24.

98. The Council would again emphasize that the General Practitioner Spens Committee, in framing its recommendations, drew attention to the length of the doctor's training and instanced this as one of the reasons for its view that incomes in general practice should be increased. Since then, the addition, in 1953, of one year's compulsory hospital training before full registration has further lengthened the qualifying period. This factor, had it then been in operation or anticipated, might well have influenced the Spens Committee to augment its financial recommendations.

99. Again, the age at which a doctor succeeds in establishing himself in independent practice would appear to be increasing. For example, though not applicable to all methods of entry into general practice, the Medical Practices Committee, in its fifth report, showed that the average age of applicants for practice vacancies advertised during the last six months of 1953 was 37½ years, that of selected applicants being 36½ years. Unfortunately the Council is not yet in a position to provide evidence about the average age of entry into general practice through other channels. It is however seeking this information, and though it is expected to show a lower figure than that for advertised vacancies, the average age of entry must inevitably have increased since pre-war.

100. Again in hospital practice the career prospects of the aspiring consultant have not been as envisaged by the Spens Committee, and this has had serious financial repercussions both upon current and total professional earnings. The Spens Committee assumed that after a young practitioner had completed his house appointments he would normally serve one year as a junior registrar (now Senior House Officer), two years as a registrar, and three years as a senior registrar, and—on the average—obtain a consultant post at about the age of 32. In practice the aspiring consultant is unlikely to obtain a consultant post before the age of 35 or 36, and many consultants do not obtain their first appointment until they are 40 years of age or more. After devoting two years at the beginning of his professional life to National Service he may well have to spend four or more years as a registrar while waiting for a senior registrar appointment. At the end of a further four years as a senior registrar (particularly in the fields of general medicine and general surgery) he will be faced with severe competition in seeking a consultant vacancy, and will count himself fortunate if he is able to do no more than retain a senior registrar appointment while awaiting a consultant post. Many senior registrars, however, have been forced by economic circumstances and the keen competition for consultant appointments to accept S.H.M.O. posts. Many of them have little prospect of further advancement, and despite their qualifications and experience may remain as S.H.M.Os. throughout their careers.

101. This means that very able men with higher qualifications and considerable experience in their chosen specialty—of which the hospital service has the greatest need—are subsisting at a salary level designed for a practitioner of lower age and attainment. This handicap remains with him always and the total career income of the doctor is affected. Furthermore, if eventually the doctor goes into part-time consultant practice, this loss in *total life earnings* is reflected in his pension, because of the late age in reaching consultant status and salary and of the fact that retirement is compulsory at age 65.

This problem needs urgent attention, for it is most desirable that a consultant position should be attained as early as possible once the practitioner is of consultant quality. Moreover if the senior registrar who has completed his training, and is in all respects suitable for a consultant post, is not appointed to one, then inevitably, as time passes, the competition from younger—and equally but no more able—men becomes more keen and the older man tends to find himself passed over.

102. Hospital Boards have a discretionary power to advance the starting salary of a doctor appointed to a consultant post after the age of 32. If Boards exercised this power more generously it could go some way towards meeting the problem referred to in the two preceding paragraphs. At the present time, however, in the face of competing demands on their finances many Boards use this power very sparingly.

103. It will be clear from what has been said above that doctors, notwithstanding the length and exacting nature of their training, are not becoming established in independent general practice or as consultants in the hospital service until a relatively late stage in their professional life.

104. This deferment of earning power also has repercussions on superannuation. In the field of general practice the Superannuation Scheme involves a special method of calculating pension rights, which are based upon $1\frac{1}{2}$ per cent of the total superannuable remuneration over a general practitioner's period of service. The same principle applies to part-time consultants undertaking up to nine sessions per week.

105. The later age at which the student now enters university and the longer period of medical training reduces the number of effective earning years. When to this factor is added the low rate of income during the long period before the doctor becomes established it will be seen that the doctor is placed at a disadvantage in comparison with those whose superannuable employment begins at an earlier age and whose pensions are determined by earnings in the immediate pre-retirement years—almost invariably their maximum—and particularly where earnings have been modified to allow for the diminishing value of money.

IV. LIFE, DUTIES, AND RESPONSIBILITIES IN MEDICAL PRACTICE

(A) THE PLACE OF MEDICINE IN THE COMMUNITY

106. The various aspects of the problem so far dealt with in this memorandum have in the main been confined to the remuneration claim itself, and it is necessary to say something about a doctor's duties and responsibilities, and the contribution which medicine has made to the community.

107. The first concerns of medicine are maintenance of health, prevention of illness, and restoration of the sick. Modern developments in medical practice have brought great benefits to the patient, and the community has gained from the decreased incidence of disease, shorter periods of illness and incapacity, more and better working years, and a greater expectation of life. These benefits have developed over the years and existed long before the State became interested in and financially responsible for the health and welfare of its individual citizens.

108. With the introduction of the Welfare State medicine has come into increasing prominence as a factor in the national economy. The Beveridge Report laid down "that a comprehensive National Health Service will ensure that for every citizen there is available whatever medical treatment he requires". Also that as "a logical corollary to the payment of high benefits in disability, that determined effort should be made by the State to reduce the number of cases for which benefit is needed". And again that the individual must "recognize the duty to be well". In the existing national economy the ambition to maintain and improve the standard of living is closely linked with the health of the nation as a whole and the individual in particular, and on these factors, as has been stressed elsewhere in this memorandum, a large measure of the productivity of the country depends. The responsibility placed on the medical profession at the present time is greater than it has ever been, for whilst there is still the accepted and direct duty of the doctor to his patient there is now a greater indirect responsibility for national health.

109. The medical practitioner has at times been referred to as a "technician". This is a complete misconception of the doctor's duties and responsibilities. It is true that medicine calls for the use of techniques, but the practice of a technique involves no more than the accurate repetition of a known procedure. Medicine, however, embraces far more than this and is at its best only if each case is viewed as a problem of the interaction of the variable factors of disease and the constitution of the individual patient.

110. A doctor working in the National Health Service is remunerated by the State for the services that he provides, but this does not necessarily represent the whole of his professional activity or his value to the community. A high standard of remuneration and satisfactory conditions of service are essential if sufficient recruits of the proper quality are to be attracted to medicine, and at the present time the relative attractions of other professions and occupations to a boy with scientific leanings have to be taken into account. Moreover the comparative freedom of members of other professions to change employment or to move from one area to another must be weighed against the monopolistic control which virtually exists in medicine to-day and isolates doctors from such freedom. If the remuneration of the profession is progressively and relatively reduced there can be little incentive, other than that of vocation, for an entry into medicine. In other parts of the world where the salaries of the medical profession have been "pegged" during an inflationary period there has been a marked fall in quality of the entry of medical students.

111. The special responsibilities of a doctor, as compared with most professional men, need to be stressed. The medical practitioner is at all times on demand and accepts continuous responsibility for the medical care of his patients. He cannot definitely state that at any given time his work will be finished, nor can he delegate any of his professional activities except to a colleague. The disruption of family life is well recognized and interruptions are frequent. In spite of this every doctor has to keep abreast of current advances in medicine and to find time for reading and study. The tradition of medicine imbues its practitioners with a sense of responsibility and independence, which must be encouraged and preserved.

112. Medicine will no doubt continue to gain recruits who are attracted by the interest and ideals of the profession, but many men of the type needed in medicine and who would have embarked on a medical career may fail to do so if the financial inducement is inadequate.

113. In the Council's view the difficulties of life in medical practice, the heavy and unique responsibilities entailed, combined with the length of training, place the doctor in a special position in the community—a factor which was clearly recognized by the Spens Committees and which formed the basis of their recommendations.

114. In the modern State those who practise medicine have a responsibility additional to their clinical work in relation to the individual patient. The vast fields in which medicine now plays a part are clearly indicated by the need for medical advice in so many State Departments and the impact of the medical angle in legislation. The practising doctor therefore in his daily work has to be fully alive to the broad social responsibilities of medicine. If the clinical practice of medicine is not maintained in a healthy and thriving condition, if its status is diminished, if its rewards are not such as to attract recruits of the right calibre, then the advice on which the community depends for future social progress is not long likely to remain of high quality.

115. The Council submits that the considerations which so greatly influenced the Spens Committees are unchanged to-day and cannot be disregarded in any assessment of the status and remuneration of the medical profession.

(B) HOSPITAL MEDICAL STAFFS—DESCRIPTION, DUTIES, AND RESPONSIBILITIES

(i) Structure of Hospital Medical Staffing

116. The hospitals in the National Health Service may be classified as follows:

- Undergraduate and Postgraduate Teaching Hospitals;
- General Hospitals providing a full range of specialist treatment;
- Special Hospitals, devoted to specific diseases, e.g., cancer;

Mental Hospitals;
Chronic Sick Hospitals;
General Practitioner (or Cottage) Hospitals;
Infectious Disease } Hospitals and Sanatoria
Chest }

117. The cottage hospitals are staffed by general practitioners, who for the most part use the beds therein to provide institutional treatment for patients who do not require specialist treatment, but who for medical or social reasons cannot so effectively be treated at home. Consultants are often attached to such hospitals to give advice at the request of the general practitioner, and in some of these hospitals some specialist services are available.

118. While the general pattern of medical staffing is similar in all hospitals with a consultant staff, that of the teaching and major non-teaching hospitals is necessarily modified because it is in them that the training of registrars, and particularly senior registrars, is usually conducted.

119. In the mental hospitals and infectious diseases and tuberculosis sanatoria a medical superintendent is normally appointed as the chief administrative officer of the hospital. Usually this officer has a mixture of clinical and administrative duties, though in a small number of cases his duties are solely administrative.

120. Members of hospital medical staff are engaged under contract with hospital authorities, and on a salaried basis, but their position *vis-à-vis* the hospital administration is unique. Upon the consultant, and through him the medical staff generally, rests the final responsibility for deciding upon the treatment of patients. Medical considerations are of primary importance in the treatment of hospital patients, and all hospital administration must be subservient to this end.

121. The clinical work of hospitals is carried out by doctors who fall into two groups, i.e., permanent and temporary. University whole-time teaching staffs whose duties involve work in the hospital service usually have an honorary contract with the Hospital Board.

122. The senior medical staff are employed under so-called permanent contracts. With few exceptions (e.g., the cottage hospital, in which general practitioners continue the treatment of their patients who need institutional care) the general responsibility for the treatment of patients in hospital wards and out-patient departments rests with consultants.

123. The only other senior permanent appointment on the hospital medical staff is the Senior Hospital Medical Officer. This grade, which is for medical staff who are described as "senior officers performing clinical duties who are not of consultant status and not registrars," was introduced at the beginning of the Service as a transitional grade for certain types of medical officer transferred from the ex-local authority hospitals, and for other doctors with limited qualifications, having experience or responsibility in a narrow field.

124. The grade was accepted by the profession on this understanding, but when the Ministry instructed Hospital Boards to appoint professional committees to review the grading of hospital staffs prior to the offer of permanent contracts in the new service, it was found that the grade was widely used for the grading of medical men who had previously been undertaking hospital work with full clinical responsibility. Since the inception of the Service many new appointments have been made in the grade following adoption of the document R.H.B. 50/96 of men with qualifications and experience equal to that of their consultant colleagues.

125. Appointments in the two senior grades may either be part-time, with the right to engage in private or other practice, or whole-time.

126. Appointments are regarded as secure until the retiring age as defined in the Terms of Service, and a consultant or Senior Hospital Medical Officer has a right of appeal to the Minister of Health if he considers his appointment is being terminated unfairly. Alteration of contract is mainly occasioned by local reorganization of the hospital service. The Minister has laid on Hospital Boards a moral obligation to do all that they can to find suitable alternative work for consultants or Senior Hospital Medical Officers whose contracts are terminated, or whose sessions are reduced, but in practice the fulfilment of this moral obligation has given rise to certain difficulties.

127. The junior grades are regarded as temporary, with periods of tenure varying from six months to four years or more in the case of the Senior Registrar. House Officer appointments are resident, as are also many Registrar and Senior Registrar posts.

128. A more detailed description of the various grades is set out below:

(2) Consultants

129. The hospital consultant stems from the hospital physician or surgeon, whose origins are very far back in medical history, in fact to the time of the 16th and 17th centuries, when the Royal Colleges of Physicians and Surgeons were founded.

130. The different types of hospital physician and surgeon have multiplied in modern times, so that there are now consultants practising highly specialized branches of their subject. Associated with these has steadily grown up a group of hospital consultants who are of similar professional attainments and whose work is ancillary to the bedside care of and responsibility for patients (e.g., pathologists, radiologists, bacteriologists, and anaesthetists).

131. The post-graduate training for the potential consultant is long, exacting, and competitive. He will hold a series of house appointments immediately after qualification, and will then be appointed to posts of higher responsibility in the registrar grades. He may be a registrar for two or more years, and a senior registrar for a further four years, and during this part of his training his degree of responsibility steadily increases.

132. In addition the aspirant to a consultant post must acquire the higher qualifications appropriate to his chosen specialty. Only a part of the necessary study may be undertaken while holding a hospital post, after which the doctor is invariably compelled to take time off to attend a course at his own expense. It is also desirable that some time should be devoted to research.

133. The consultant is thus one who has undergone the appropriate post-graduate training designed to produce a man of wide clinical and practical experience, with full academic qualifications in his specialty and as great a knowledge of his subject as possible.

134. The consultant is the leader of a team which the hospital provides for the fullest treatment for the sick. This principle of consultant responsibility for work in a modern hospital is fundamental. Upon it the quality of hospital medical service directly depends. Sufficient consultants should always be appointed for this to be a reality in practice. Similar considerations apply in the staffing of the diagnostic and other special departments (e.g., pathology, radiology). The consultant is in charge of a number of beds, of a department, or both, and the junior members of his team are his assistants, and are responsible to him.

135. The word "consultant" defines the function of a hospital doctor of this status in relation to general practitioners, both as regards hospital and private practice. The consultant is not normally approached direct by the public, but, just as a barrister accepts his clients from a solicitor, so the consultant receives his patients in private practice from the general practitioner. He advises and helps the latter in the treatment of his patients. As far as hospital is concerned consultants receive their patients in most instances from general practitioners through out-patients, or in the case of an emergency direct into the hospital beds.

136. By virtue of his professional authority the consultant carries, in addition to his purely professional responsibilities, considerable responsibility for advising and guiding the hospital administrative authorities on matters of policy and development. The incidence of these duties varies from time to time, and is often heavy. It adds considerably to the service rendered by the consultant to his hospital.

137. Consultants are chiefly responsible for the clinical teaching of under-graduate and post-graduate students and of various types of auxiliary workers and do much of such teaching themselves. They are also in a large part responsible for the advancement of medicine by research. The position of such persons in the community and the remuneration they receive should be commensurate with their authority, responsibility, and abilities. It is most important for the future of medicine that nothing should happen to diminish this status or the standard required of persons holding it.

(3) Senior Hospital Medical Officers

138. The Senior Hospital Medical Officer grade was not referred to in the Spens Report and it was common ground between the Joint Consultants Committee and the Ministry that after being used initially for the assimilation of medical staff already engaged in the hospital service, the need for the grade was temporary and that the numbers in it should diminish.

139. In 1949-50, in order to clarify the future use to be made of the grade, discussions took place between the Ministry and the Joint Consultants Committee which resulted in the issue of circular R.H.B. 50/96—which is attached as *Appendix X*—defining those posts in the medical establishments of hospitals which might be designated in the Senior Hospital Medical Officer grade. This circular is still operative and a considerable number of new appointments have been made in accordance with a varying interpretation of its provisions.

140. The Senior Hospital Medical Officer grade therefore includes:

(a) Doctors employed before 1948 by local authorities;

(b) A number of general practitioners who were working in hospitals in 1948, especially in the provinces and country districts, where it was customary for suitably qualified or experienced doctors to combine general practice with the practice of a specialty in the local hospital. A number of these have subsequently given up general practice and are now engaged solely in their specialty.

(c) Senior Hospital Medical Officers appointed following the adoption of the circular R.H.B. 50/96.

141. Categories (a) and (b) therefore consist of those practitioners who were given the personal grading of Senior Hospital Medical Officer on their individual qualifications and experience, but it does not follow that the posts they hold are necessarily of Senior Hospital Medical Officer status. Indeed, of the 2,000 Senior Hospital Medical Officers graded as such in the early days of the Service some 680 held appointments in specialties where the grade is no longer permitted. It can therefore be expected that when they retire they will be replaced by consultants. Inevitably some of the other graded Senior Hospital Medical Officers, in specialties where the grade is permitted, are also occupying posts which would more appropriately be filled by consultants.

142. Many of the 2,000 originally graded as Senior Hospital Medical Officers felt that they had been unjustly treated and should have been placed in the grade of consultant. Some mistakes in grading were undoubtedly made, and a number of Senior Hospital Medical Officers have been upgraded as a result of further grading reviews.

143. Some of the Senior Hospital Medical Officers who are in the grade on the basis of their personal grading are known to be occupying consultant posts, or to be working with full and independent authority. Committee B of the Medical Whitley Council has recently agreed to undertake a review of such Senior Hospital Medical Officers with a view to securing that those who are satisfactorily discharging consultant duties shall be paid on the consultant salary scale. In this empiric manner an attempt is being made to deal with one of the problems of the grade, which is the absence of any machinery for ensuring just treatment for the Senior Hospital Medical Officer who with the passage of time fits himself for the consultant employment which he is undertaking.

144. It is in category (c) that expansion of the S.H.M.O. grade has taken place. The Council feels that the time has come to re-examine circular R.H.B. 50/96 in the light of experience and of changes in the training programme for consultants. The temptation to effect a financial saving by appointing Senior Hospital Medical Officers instead of consultants is a very real one, especially where the reasons for the defined limited field of the Senior Hospital Medical Officer are not fully appreciated. The Council believes that the grade has been exploited. The grade has expanded considerably by the appointment of Senior Hospital Medical Officers under circular R.H.B. 50/96, and many of these Senior Hospital Medical Officers have all the qualifications and training of the consultant and are engaged in duties and responsibilities indistinguishable from those of the consultant. Appointments in the Senior Hospital Medical Officer grade should in future be strictly confined to certain special and narrow fields of limited responsibility, and apart from these exceptions there should be no career grade in the hospital clinical service other than that of the consultant.

145. The Senior Hospital Medical Officer enjoys the same security of tenure in his appointment as the consultant, but though a senior permanent grade, it is felt that it carries an unwarranted stigma of professional inferiority and there is throughout the grade great dissatisfaction regarding status, prospects, and remuneration.

146. The Senior Hospital Medical Officer circular does not operate in Scotland, and in that country there are no hard and fast rules governing the appointment of Senior Hospital Medical Officers. This has led to some criticism by the profession in Scotland that Senior Hospital Medical Officers have been appointed in place of consultants.

(4) Junior Hospital Medical Officers

147. The Junior Hospital Medical Officer grade was created chiefly for practitioners employed in mental hospitals, tuberculosis and infectious diseases sanatoria, and who exercise junior functions under supervision. Originally a permanent grade, it has recently been used, in agreement with the Ministry, for short-term appointments of up to four years' tenure. There are less than 500 doctors in this grade, which should disappear if satisfactory agreement can be reached on hospital medical staffing.

(5) Senior Casualty Officers

148. In some hospitals where it has been found desirable to appoint a Casualty Officer with rather more experience than the type of doctor usually appointed, a Senior Casualty Officer may be appointed at a salary within the salary range of the Senior Hospital Medical Officer. The appointment is a temporary one for a period not exceeding four years. The type of candidate usually appointed to such a post is a senior registrar in general or orthopaedic surgery who has completed his training and is waiting for an opportunity to obtain a consultant post.

(6) Senior Registrars

149. The Senior Registrar grade is the training grade for the future consultant. Appointments in the grade are essentially of limited duration as the senior registrar is being trained and is training himself for a consultant post. The normal tenure of a senior registrar post is four years, subject to annual review.

150. The Senior Registrar occupies a responsible position. He may well have held five or six years of postgraduate hospital appointments before becoming a Senior Registrar, and gains his appointment in open competition. He commonly holds the academic qualifications of a consultant, and in common with the consultant his duties often include the teaching of medical students.

151. The problems of this grade have been considerably increased with the National Health Service. In the beginning of the Service members of the grade multiplied out of proportion to the clinical or training requirements. Large numbers of young men coming out of the Forces after the war availed themselves of the opportunity of coming back to spend a period of time in hospital under the post-graduate further education scheme. During this time they read for and obtained higher qualifications; at the same time they did a useful job of work in the hospital service. Their value in this respect was quickly recognized and the service of these same men was retained by making them Senior Registrars or Registrars. Many of these posts became a permanent part of the hospital establishment after their original holders had left them. There have thus been so-called training posts far in excess of the prospective numbers of consultant vacancies. It was hoped in the expansionist mood of the immediate post-war years that the consultant establishment would enlarge correspondingly and that there would be a consultant career for a high percentage of these men.

152. This hope has not been realized in practice. Despite the expansion which has taken place in the consultant service, there are now large numbers of fully trained Senior Registrars in the major specialties with little prospects of becoming consultants in the National Health Service. Some of these men are being held in what are known as "transitional" posts.

153. It is necessary that in the future the numbers of senior registrars shall be closely related to estimated consultant vacancies.

154. There has been considerable abuse of this grade since the Service began, particularly in general medicine and general surgery, which are the basic clinical grades and attract most of the ablest men who desire to become consultants. A large number

of Senior Registrars have been carrying consultant responsibilities without supervision and the establishment of consultant physicians and surgeons has not been increased to meet all hospital requirements.

155. The appointment of more consultant physicians and surgeons and a corresponding reduction in the numbers of senior registrars is very much overdue. In this alteration of ratio lies the solution to the career problem, and the net financial cost, if this is done with efficiency, should not be very great.

(7) Registrars

156. The registrar, as distinct from the senior registrar, holds office for a period of two years, but hospital authorities have a right to re-appoint him for successive periods of two years if they wish in the same or in another specialty. The numbers are not restricted, and, although probably most registrars have, as their ambition, an eventual consultant career, it is only a proportion of them that succeed in gaining promotion in the hospital service. The same problems that affect senior registrars to a considerable extent affect the registrar also. If he holds a post for two periods of two years, or even more (some registrars have held appointments in the grade for six or seven years), he is usually in possession of higher medical or surgical qualifications and in some instances may even be doing work that should be done by a consultant. He is the victim, therefore, of problems similar to those of his more senior colleague, the senior registrar. Moreover, when Hospital Boards reduced the number of senior registrars on the instructions of the Ministry in 1951-52, the number of registrars increased. This has tended to aggravate the promotion problem. The number of applications for registrar appointments is gravely falling off. The duties of the registrar may include the teaching of medical students. Like the House Officer (see below) he is often resident, and his hours of duty are long and onerous.

(8) House Officers

157. The grade of House Officer has been long established in hospitals in this country. The House Officer has, in the past, been paid little, as his post has been looked upon essentially as an educational appointment preparatory for any branch of medicine. The majority of men holding house posts do not continue in the hospital service, but the holding of such posts is desirable in whatever branch of the medical profession the practitioner proposes to make his career. The newly qualified doctor must hold two house appointments before he can be fully registered as a medical practitioner. Thereafter further house posts may and are invariably held by the fully registered medical practitioner.

158. Circumstances to-day have altered also in other ways. A percentage of House Officers now are married and have families. Apart from house appointments being preparatory posts, the changes in medicine and surgery have made it necessary that there should be increasing numbers of House Officers to deal with the essential work of a modern hospital. Being a resident doctor he is on call for emergencies at all hours of the day or night, and commonly works for long hours. Hospitals could not function without him. With the high cost of living of to-day it is therefore essential that he should receive an adequate income.

159. The House Officer (or Senior House Officer) should not to-day be paid as a postgraduate student. He has already completed six years as a medical student and his duties are of a responsible nature, including the completion of statutory certificates and attendance at court. Certainly in any post-registration house appointments that he holds he should be paid a fair income for the actual work that he does.

(9) University Whole-time Teaching Staff and Research Workers

160. It is estimated that there are approximately 2,000 medical teachers and research workers (including professors) in the following categories:

- those who instruct medical and dental students in the basic scientific subjects and have no clinical commitments;
- those who instruct medical students in their clinical years and who also carry out duties, with or without an honorary contract, in the National Health Service hospital service;
- research and laboratory workers with no teaching commitments, many of whom are employed by the Medical Research Council—this group includes some of the staff of the Public Health Laboratory Service.

161. Many medical teachers, particularly those in category (b) above, also carry out duties within the National Health Service which are identical with those of their National Health Service colleagues.

162. The work of medical teachers and research workers determines the present and the future of medical practice and research in this country. It is essential, therefore, that recruitment and standards should be maintained, if not improved.

163. The remuneration of these doctors is largely related to that of university staff as a whole and is based on scales recommended by the University Grants Committee.

164. The University Grants Committee is believed to have taken into consideration National Health Service rates of pay, but parity has not been achieved at any level.

165. In many areas certain of the services of special departments (particularly pathology) are the responsibility of university staff with honorary contracts in the National Health Service. The effect of their being remunerated at a lower level than that of National Health Service colleagues is that the teaching hospitals for which the work is carried out are obtaining the services of consultants and assistants at very much cheaper rates than obtain in other hospitals. This is at the expense of the university personnel employed.

(C) GENERAL PRACTICE

(1) The Scope and Arduous Nature of General Practice

166. The nature of the general practitioner's calling is such that it is wellnigh impossible simply by referring to certain tasks and responsibilities to define the precise extent of his duties. He is in fact responsible for the overall medical care of his patients at all times of the day and night, and irrespective of age and weather conditions is liable to be called upon to meet any contingency which may arise in the area of his practice. Whilst it is true that a general practitioner has the facilities of the hospital service behind him, and domiciliary consultations are available under the National Health Service, the fact that a consultant opinion is sought in no way implies that the care of the patient is no longer the responsibility of the general practitioner. Indeed, in an emergency the general practitioner must be able to cope with a serious case under adverse conditions, and the skill and care which he then extends may make all the difference to the patient's chances even if subsequently transferred to the hospital service.

167. The general practitioner bears a heavy burden of responsibility, for, unlike members of other professions, he must be on call for twenty-four hours a day and is responsible for making his own deputizing arrangements on the infrequent occasions when he is able to escape from his practice. This continuing responsibility which the general practitioner accepts as part of his calling is in sharp contrast with the general tendency in other walks of life, e.g., the Civil Service, where following the report of the Priestly Commission a five-day week was recently introduced and taken into account in fixing salary scales. The extension of automation, which can have little effect on the general practitioner's work, will accelerate this tendency for a shorter working week in the future. This illustrates and reinforces the Council's view that it is wellnigh impossible to draw any effective comparison between one profession and another.

168. The general practitioner is assumed to be at all times fit and mentally alert, for the patient not unnaturally expects his doctor to be able to deal effectively and promptly with any one of the many serious emergencies which may arise at any time of the day or night even though the doctor may be at the point of exhaustion following a prolonged spell of duty.

169. The very nature of a general practitioner's work makes him liable to spells of severe physical and mental exhaustion, even though it so often happens that he is called upon to make a decision—on which the patient's life may depend—at a time when both these factors may operate. Such decisions are frequently made when no outside opinion or help is possible, and, although all this is accepted as an essential facet of his vocation, it places a heavy strain on the general practitioner which has no parallel in other professions.

170. In addition, the general practitioner's working life must be viewed against the risk of litigation or complaints by patients not only of his professional skill but of any apparent discourtesy, however provoking the circumstances may be.

171. Any patient may make a complaint about the general practitioner, however trivial, and the doctor may in consequence be called before a Medical Service Committee to justify his action. The disciplinary machinery necessary in a publicly organized service of the present kind is additional to the powers exercised by the General Medical Council over the whole profession.

172. In addition to the high educational standards which are required, the general practitioner must possess certain personal qualities if he is to be a family doctor in the true sense of the words. The general practitioner's intimate relationship with those he serves leads to his assumption of the role of guide, philosopher, and friend to his patients. He must be a good mixer, one who is equally at home with all classes of society and an individual who has the full confidence of his patients. Above all he must be a profound student of human nature and possess immense reserves of mental and physical stamina. He has very limited time for recreation and leisure, since the calls on his service are continuous and exacting and little dependence can be placed upon him for social or family engagements.

173. The doctor's wife and family inescapably share the strain of general practice. Many doctors' houses are large and old and not easily adaptable to present-day conditions, when domestic help is virtually unobtainable. In other walks of life the situation would be met by moving to a smaller, more easily and cheaply run house, but a doctor is tied to the area of his practice, so this is often impossible. Meals are irregular and must be taken at times to meet the needs of the practice and not the convenience of the family. For example, general practitioners hold an evening surgery for the benefit of those at work. This may finish at a late hour and be followed by visits to patients, requests for which have come in late in the day. This often means that meals must be duplicated. At night emergency calls are disturbing to those living in a doctor's house as well as to the doctor who must respond to them. Domestic duties must be undertaken amidst a succession of telephone calls and patients calling at the house both in and out of normal surgery hours. Indeed, the doctor's family provides for the National Health Service a formidable ancillary force.

174. Some indication of the effects of the doctor's arduous life and heavy responsibilities can be obtained from the Registrar General's analysis of occupational mortality rates in successive age groups at the 1931 population census date.

175. The available information for *males* in England and Wales is as follows:

Death Rates from All Causes
(Death Rates for All Males—100)

	Age Group						
	25—	35—	45—	55—	65—	70—	75—
1931							
Doctors	92	94	108	111	103	95	103
All Professional Men ...	83	79	88	95	98	93	96

From: 1931 Census, Decennial Supplement, Part Iia, Occupational Mortality, pp. 217, 256.
Doctors: Physicians, Surgeons, Registered General Practitioners.
All Professional Men: Social Class I.

It must be noted that, in each age group, the death rate for doctors or professional men is expressed as a percentage of the death rate for all males. For example, in 1931, the death rate among doctors aged 55–65 was 11 per cent higher than the death rate among all males in the same age group, and 16 per cent higher than the rate for all professional men of the age group.

176. The Council had hoped that the results of the next survey based on the 1951 population census data would now be available, but unfortunately this latest analysis has not yet been published by the Registrar General.

177. On the evidence of the 1931 data, however, death rates among doctors were considerably higher than for all professional men at all ages—and in the critical age groups from 45 to 70 higher also than the average for all men.

178. It is also of interest to note the results of an investigation carried out in 1952 into coronary heart disease in medical practitioners.* Here again, as the following table shows, the incidence of the disease fell most heavily upon those in general practice:

Incidence of Coronary Heart Disease

Standardized Rate per 1,000 Men Aged 40-59

General Practitioners	7.1
Other doctors	3.3
Miscellaneous, non-medical group	2.5

(2) Overall Responsibility for the Medical Care of the Population.

179. The Council must also refer to another of the major principles accepted by both the profession and the Government, namely, the recognition of the overall responsibility of the profession for the medical care of the population as a whole.

180. Not only is the general practitioner in the Health Service responsible for patients on his own National Health Service list, but he is also liable to treat any person who happens to be in his area. Again, he may be summoned to any emergency—even where the patient is not normally a National Health Service patient. He may even have patients arbitrarily allocated to him by the Executive Council. His responsibility for general medical services is thus both unlimited and continuous.

181. In every other walk of life the professional man's responsibilities are limited by the individual arrangements which he makes with members of the public. No solicitor or accountant, for example, is under any obligation to provide professional services without limitation to any member of the public who cares to call upon him. In the case of National Health Service general practice any failure on the part of the doctor to answer a call for assistance from any person, whether on his list or not, can lead to a complaint by a patient and an investigation by a Medical Service Committee.

182. Similarly with off-duty time and holidays the general practitioner remains at all times personally responsible for the medical care of his patients. He must provide a deputy whenever he is absent, and even then he must accept responsibility for anything that may happen during his absence.

183. The principle of collective responsibility, inescapable in a publicly organized service, plays no part in the life of other professions, who are under no obligation to provide continuous cover.

184. There can be no doubt that this principle of collective responsibility was accepted by the Government, and the following extract from the Minister's Case to Mr. Justice Danckwerts sets out their policy on the matter:

"43. In negotiations between the Parties, preparatory to the coming into force of the National Health Service, it was agreed with the British Medical Association that the profession would accept collective responsibility for all the civilian population taking advantage of the General Medical Services and that there should be a Central Pool to provide for the remuneration of general practitioners providing General Medical Services."

It will be seen that the acceptance of this principle led, with the agreement of the profession, to the Pool method of payment. Under this method general practitioners as a body are entitled to an agreed global sum of money corresponding to the Spens recommendations as interpreted by the Danckwerts Award for accepting overall responsibility. In the Council's view this method represents the only practical way of remunerating a profession which accepts an overriding responsibility shared by agreement between its own members. The Council is certain that the retention of this method of payment is essential and maintains that any question of distribution of the global sum between individual members of the profession should rest with the profession in consultation and agreement with the Ministry of Health.

185. The global sum referred to in paragraph 184 above represents total general practitioner remuneration from all sources, i.e., not only general practice in the National Health Service but maternity services, hospital and public health appointments, medical

* Coronary Heart Disease in Medical Practitioners—*British Medical Journal*, March 8, 1952.

boards, superannuation contributions, and private practice, etc. (By way of illustration a detailed computation of the Pool for the years 1953-54 and 1954-55 is set out in *Appendix XI*.) The Ministry's contribution for General Medical Services, known as the *Central Pool*, is arrived at by deducting from the global sum the aggregate income earned from all other sources (including private practice). To the extent that such income may increase or decrease, the size of the Central Pool varies. Thus the global sum is the maximum overall income and, whilst other professions can supplement their income by undertaking additional work, this cannot happen in general practice, where additional income is merely deducted from the amount which the Ministry pays into the Central Pool. It is therefore vital to the profession that the global sum is adequate for its purpose.

186. For all these reasons the Council wishes to record its firm conviction that any departure from the Pool method of payment would be a breach of the undertaking given by the Government to the profession when it entered the Service.

(3) Financial Incentives in General Practice

187. In this memorandum, the Council has as yet made no mention of the vital need for re-establishing suitable incentives in general practice. Such a need in general practice, as in other fields and professions, was clearly recognized by the Spens Committee, who in their recommendations stated that in a small proportion of cases it should be possible for general practitioners to obtain *net* incomes of at least £2,500 per annum in terms of 1939 values of money. Translated into present-day money values, such a level (approximately £6,250) is now unobtainable in relation to the size of the Central Pool and the maximum permitted list of 3,500 patients allowed in general practice. In fact, the maximum net income from capitation fees and loadings on a list of this size, even allowing 8 per cent for the distribution of the balance of the Central Pool each year, only approximates to the level recommended in terms of 1939 values of money. It is possible if partnership terms advantageous to the senior partner(s) can be made for this level to be exceeded, but even this can only be effective for a limited time, for the terms of partnership agreements are governed to no small extent by the National Health Service Acts.

188. There can be a similar temporary financial advantage in certain cases where an assistant is employed. This also is limited by a number of factors. Assistantship arrangements are now subject to stringent reviews by Executive Councils. The average extra cost to a doctor who employs an assistant is such that only in the upper range of the additional list of patients allowed in respect of the employment of an assistant can he hope to derive any financial advantage.

189. In fact, in nearly all cases, both when taking an assistant and in the initial stages of a partnership, the principal suffers a financial loss which cannot be offset as in the days before the National Health Service, when the incoming practitioner purchased his share of the practice. Furthermore, unless the practice is capable of steady expansion this leeway can never be made up. The fact is that the level indicated by the Spens Committee as providing a suitable incentive is entirely absent from the present financial arrangements. It is true that substantial additional remuneration over and above the total capitation fees and loadings is paid out from the Pool, but it would be quite wrong to assume that these are distributed anything like proportionately to earnings from capitation fees. Indeed, the Council holds the view that a general practitioner with a maximum list is less likely either to practise in an area where the opportunity for other medical work exists or to find time for other professional activities which would bring him in a return anything like proportionate to his remuneration from capitation fees and loadings.

190. Again, it must be emphasized that if general practitioners as a group earned more outside their general practice, e.g., for work in hospitals, which has increased and is increasing, then the operation of the Central Pool sees to it that they get less for their general practice; the net average is maintained.

191. The present average earnings of £2,222 includes both the superannuation contributions of the doctor himself (5 per cent, or £120) and that of the Exchequer (8 per cent or about £160).

192. There are therefore three average net earnings figures to be borne in mind; the full £2,222, a figure of about £2,060 excluding Exchequer superannuation contributions, and one of about £1,940 excluding superannuation provisions altogether.

(4) The Changing Pattern of General Practice

193. Not only has the quantity of work increased since the inception of the National Health Service—perhaps this was to be expected—but the qualitative element has changed with the advances of medical science. On the first issue it is not easy to estimate the effect of the National Health Service on the volume of service required of the family doctor, and no accurate or specific figures are available. It is, however, common knowledge that the waiting time in doctor's surgeries is increasing, and it is the general experience of practitioners that the demand on their services has increased since the inception of the Service.

194. The root causes are not difficult to find. Many illnesses formerly requiring admission to hospital are now treated successfully by the general practitioner in the home. The increasing longevity of the population generally has likewise led to greater demands upon the general practitioner's time. Many diseases have lost their fatal effect as a result of modern therapeutic measures, but the patients nevertheless often need continuing and careful treatment. Again, the increasing tendency to early ambulation after operation adds to the general practitioner's responsibilities and work. Modern diagnostic procedures in the surgery are similarly more time consuming. It can fairly be said that the public has come more and more to rely on the doctor for every aberration from the normal and is increasingly seeking advice for the preservation of normal health and for the prevention of illness. The introduction of a "free" health service has naturally increased the calls upon the general practitioner. There has, for instance, been a marked rise in the number of late calls, and undoubtedly there is a section of the public, admittedly small, who make unnecessary calls upon the doctor's time.

195. As far as the qualitative element is concerned, the field of psycho-neurosis provides an excellent illustration of present-day trends. Perhaps in recent years there has been no section of medicine which has called for so much time and care as that of the mentally sick. There is no doubt that the intense pressure of modern life, its speed of movement and action, completely altered social standards and many other factors have affected large sections of the public. The general practitioner is frequently consulted by persons who break down under stress and quite often attend the surgery with ill-defined symptoms simulating organic disease but which are really based on concealed fears. To-day this type of patient requires much more time and painstaking examination than ever before. Not only does he require sympathy and reassurance, but he is only too well aware of the wide field of costly investigation available at hospital and often is not satisfied until many of these tests have been undertaken and proved negative. The general practitioner has a difficult and time-consuming task in separating the organic from the psycho-neurotic. Demands for "stimulants," the fight against depression and insomnia, the craze for slimming, and, more recently, "tranquillizers," are examples of the type of new problems which are facing the doctor to-day. All told, society expects much from the family doctor and makes many demands upon him which must be met if he is to fulfil his proper place in society. He in turn has a right to expect security and a feeling of confidence in his "employers".

(5) Postgraduate Education

196. The administration of new drugs and forms of treatment have completely changed the course of many diseases. Medical science is never static, and a general practitioner must at all times keep himself abreast of advances in pharmacology and therapeutics, where new remedies are constantly under trial and review. It is necessary for a doctor to read widely medical journals and new text-books, to attend meetings and clinical demonstrations, and, whenever possible, to take post-graduate courses.

197. It cannot be sufficiently emphasized that the general practitioner is the first barrier against disease, and it is only by his intimate knowledge of the patient's medical history and social environment that he is able to make a considered diagnosis, and by his constant application to post-graduate study to make the latest advances in medical research and treatment available to his patients.

198. Post-graduate study has become an inescapable part of a doctor's life and was recognized by the Spens Committee as an important factor in assessing the general practitioner's remuneration.

(6) Comparative Lack of Mobility in the Profession

199. Members of other professions are free to practise wherever they wish. The medical profession accepted in the interests of the nation that there should be some restriction on the movement of doctors in the National Health Service in order that the existing medical personnel should be spread evenly to meet the needs of the various parts of the country. This means that a general practitioner has a restricted choice so far as the area of his practice and residence are concerned. Similarly, it is extremely difficult for an established practitioner to change his area of practice or his residence.

200. Indeed, the opportunities are almost negligible, for, in spite of efforts made by the profession, the Medical Practices Committee, and the Ministry to facilitate the exchange of practices, the actual number of exchanges which have come to fruition since the Service began some nine years ago is only twenty-three in England and Wales.

201. Another major factor which has given rise to the profession's immobility has been the prohibition of the right to buy and sell the goodwill of medical practices. Before 1948, a general practitioner who through ill health or because of illness in his family or who in later years wished to exchange the heat and burden of a busy, industrial practice for lighter work in a more desirable area could realize the value of his goodwill and achieve his objective by outright purchase of a smaller practice. The prohibition on the sale of goodwill means that such a situation is impossible to-day.

202. The Government's decision to abolish the purchase and sale of practices has led to a serious and understandable grievance amongst older practitioners. A practitioner before the National Health Service Act received for his practice when he sold a share of the whole a capital tax-free sum. A successful industrious practitioner would substantially increase the value of the goodwill. The Government compensated those doctors when they abolished this right by compensating at the 1946 value of those practices. This sum was payable (save in exceptional cases) only when a doctor retired from the National Health Service. This frozen money has now depreciated. Its present value is only 61·3 per cent of its value in 1946.

203. Finally, it must be pointed out that a doctor by the very nature of his training is unable to find employment in any other field. There are few, if any, opportunities open to doctors outside medicine. This is in contrast to other professions, where opportunities for changing from professional to executive work—particularly in industry—are quite common.

V. SUMMARY

204. It will be seen that this preliminary memorandum of evidence falls into three main sections, first, the Council's view of the Commission's task, second, the claim itself (set out in detail in *Appendices VII and VIII*) and the events leading up to that claim, and, third, a number of sub-sections which demonstrate the unique position which the medical practitioner holds in the community. These latter sub-sections illustrate the inherent difficulties of drawing any valid comparison between a doctor's training, responsibilities, and the heavy strain to which he is subjected, and the nature of the work undertaken by other professions, most of which have not the same vocational aspect.

205. The Council submits again that its claim is unassailable on moral grounds and that the profession has a right to expect that the Government will honour the unequivocal promises made to it that remuneration would be based upon the recommendations of the two Spens Reports, the arguments for which have been set out in full in earlier paragraphs of this memorandum.

206. The medical profession has given loyal and unstinting service to the community since it agreed to co-operate in the National Health Service, and its patience has been sorely tried by the Government's curt rejection of a just claim—a claim, moreover, which was not submitted until after five years of restraint in deference to the general economic position of the country.

207. The Council has a duty to ensure that the position of the profession is not worsened simply because the State has now assumed responsibility for the greater part of its remuneration. It looks to the Commission not only to redress the underpayment which it has suffered over the years but to recommend such levels of remuneration for the future as will maintain the principles established by the Spens Reports and thus attract to medicine a proper share of the best recruits.

The British Medical Association's Preliminary Memorandum of Evidence was accompanied by eleven Appendices, of which the following are already available in published form:—

- Appendix I. Report of the Inter-Departmental Committee [the Spens Committee] on Remuneration of General Practitioners. (May, 1946. Command 6810.)
- Appendix III. The Award of Mr. Justice Danckwerts. (Published in the Supplement to the *British Medical Journal*, 29th March, 1952.)
- Appendix IV. Report of the Working Party on the Distribution of Remuneration among General Practitioners. (H.M.S.O., 1952.)
- Appendix V. Report of the Inter-Departmental Committee [the Spens Committee] on the Remuneration of Consultants and Specialists. (May, 1948. Command 7420.)
- Appendix VI. Whitley Councils for the Health Services (Great Britain) Medical Council: Committee B. Terms and Conditions of Service of Hospital Medical Staff. (M.D.B. Circular No. 17, 21st May, 1954.)
- Appendix VII. Remuneration of General Practitioners and Hospital Medical Staff. Case submitted to the Ministers by the Profession. (*B.M.J.* Supplement, 28th July, 1956.)
- Appendix VIII. Remuneration of General Practitioners and Hospital Medical Staff. A Supplement to the Outline of the Case. (*B.M.J.* Supplement, 3rd November, 1956.)
- Appendix IX. Changes in the Distribution of Higher Incomes. (An article by Professor R. G. D. Allen, C.B.E., M.A., D.Sc.(Econ.) previously published in "*Economica*" in May, 1957.)
- Appendix X. Ministry of Health Circular R.H.B. 50/96 on the Senior Hospital Medical Officer Grade.

APPENDIX II

IN THE MATTER OF AN ADJUDICATION BETWEEN:

**THE GENERAL MEDICAL SERVICES COMMITTEE OF THE
BRITISH MEDICAL ASSOCIATION**

(representing the general practitioners in the National Health Service)
and

**THE MINISTER OF HEALTH AND THE SECRETARY OF STATE
FOR SCOTLAND**

STATEMENT OF CASE FOR THE GENERAL MEDICAL SERVICES COMMITTEE

Terms of Reference:

"To determine the size of the Central Pool, after taking account of remuneration from all other sources received by general practitioners, in order to give effect to the recommendations of the Spens Committee, having regard to the change in the value of money since 1939, to the increases which have taken place in incomes in other professions and to all other relevant factors."

The Spens Committee

1. In February, 1945, and in anticipation of the setting up of the present National Health Service, the Minister of Health and the Secretary of State for Scotland (hereinafter

referred to as "the Ministers") appointed an inter-departmental committee, under the chairmanship of Sir Will Spens, with the following terms of reference:

"To consider, after obtaining whatever information and evidence it thinks fit, what ought to be the range of total professional income of a registered medical practitioner in any publicly organized service of general medical practice; to consider this with due regard to what have been the normal financial expectations of general medical practice in the past, and to the desirability of maintaining in the future the proper social and economic status of general medical practice and its power to attract a suitable type of recruit to the profession; and to make recommendations."

2. This Committee received evidence from a number of medical bodies and from various departments of State. In addition, the Committee had before it an analysis, prepared by Professor Bradford Hill, of the result of an inquiry conducted by the British Medical Association into the remuneration of general practitioners in the years 1936, 1937, and 1938.

3. The Report of the Spens Committee was presented to the Minister and the Secretary of State in April, 1946, and was laid before Parliament in May of the same year (Cmd. 6810). The Report is annexed as Exhibit A, and it is submitted that this Report is the foundation of the present inquiry, for the reasons following.

4. Parliament was engaged, at the time when the Committee's Report was laid before it, in considering the Bill which subsequently became the National Health Service Act, 1946. The Government lost no time in accepting the recommendations of the Committee without qualification. On July 22, 1946, the permanent secretary to the Ministry of Health gave the following undertaking on behalf of his Minister: "The Minister desires to make his attitude to the Spens Report quite clear. He fully accepts the substance of the recommendations upon the general scope and range of remuneration which general practitioners should enjoy in a public service."

5. It was on the basis of this undertaking that general practitioners agreed to enter the National Health Service. In a moral though not in a legal sense, it may fairly be said that the recommendations of the Spens Committee amount to a quasi-contract between the profession and the State. The purpose of these proceedings is to determine what funds are required to give this quasi-contract full force and effect, with effect from the beginning of the present National Health Service—namely, from July 5, 1948.

The "Working Party" and its Relationship to these Proceedings

6. The recommendations of the Spens Committee are concerned both with the size of the professional incomes to be ensured to general practitioners in a publicly organized health service and with the spread of those incomes over the range of practitioners engaged in the service. The present reference, however, is concerned only with the total sum required to give effect to the recommendations, but not with the manner in which that total sum should be distributed among the individual practitioners or the various categories of practitioners indicated in the Spens Report.

7. The manner of the distribution of that total sum is the subject of an independent and separate enquiry which is being conducted by a body known as the "working party," which consists of representatives of the Minister of Health, Secretary of State for Scotland, and the General Medical Services Committee. It is submitted by the general practitioners that the ascertainment of the proper amount of the total sum required to give effect to the recommendations of the Spens Committee is a matter which should be kept separate and distinct from the question as to how that total sum, when it is ascertained, is to be distributed among the individual practitioners concerned. The view of the General Medical Services Committee on this matter is confirmed by the terms of reference of the working party, which are as follows:

"To secure an equitable distribution of the Central Pool based upon the recommendations of the Spens Committee, the object being to enable the best possible medical service to be available to the public, and to safeguard the standard of medical service by discouraging unduly large lists; at the same time, to bring about a relative improvement in the position of those practitioners least favourably placed under the present plan of distribution, to make it easier for new doctors to enter practice, and to stimulate group practice."

The Report and Recommendations of the Spens Committee

8. In determining the size of the Central Pool, the first two of the Spens Committee's seven recommendations are of primary importance. These two recommendations are that, in respect of a publicly organized service:

- (1) A scheme should be devised which will ensure that between 40 and 50 years of age approximately 50 per cent of general practitioners receive net incomes of £1,300 or over, and which will also secure, so far as practicable, that between 40 and 50 years of age approximately three-quarters receive net incomes over £1,000, that approximately one-quarter receive net incomes over £1,600, that slightly less than 10 per cent receive net incomes over £2,000 and that, in a small proportion of cases, it is possible to obtain net incomes of at least £2,500. By net income we mean gross income less such professional expenses as are allowed by the Inland Revenue for Income Tax purposes. Here also, as in the body of the report, we are expressing our recommendations in terms of the 1939 value of money.

Note (i).—The above proposal is approximately equivalent to the augmentation of net incomes in 1939 by £200 in the case of incomes between £400 and £1,200 and, in the case of incomes over £1,200, by £200 at £1,200, diminishing progressively to nothing at £2,000.

Note (ii).—We say nothing about reducing the high percentage of incomes below £700, since this would follow automatically from the operation of these recommendations.

- (2) Before 40 and after 50, practitioners should be remunerated at the rate applicable between 40 and 50 to the burden and responsibilities of practice which they are in fact carrying.

9. These recommendations contemplated an improvement in the earnings of a large number of general practitioners comprising in the aggregate by far the majority of those engaged in general practice. The recommendations gave effect to the opinion, expressed by the Committee in various passages in their Report, that in the years before the war the earnings of general practitioners as a whole were too low. The matter is expressed in paragraph 8 of the Report as follows:

"Having regard to the length of training, to the arduousness of the general practitioner's life compared with that in other professions, to the greater danger to health, to the skill and other qualities required and to the degree of individual responsibility, we are unanimous in holding that the percentages of low incomes are too high. Having regard to the same facts, we are clear also that the proportion of practitioners able to reach a net income of £1,300 or over is too low. We consider that unless conditions are substantially improved in both these respects, and on the basis of a pre-war value of money, the social and economic status and the recruitment of general medical practice could not, in the long run, be maintained."

10. There are two other aspects of the Report of the Spens Committee to which special attention should be drawn at the outset:

- (1) Both in formulating their recommendations and in explaining them in the body of their Report, the Spens Committee spoke entirely in terms of net incomes, such incomes being the gross receipts of general practitioners less the amount allowed as deductions for professional expenses by the Income Tax authorities. (Report, paragraph 21.)
- (2) The recommendations of the Committee are made throughout in terms of the 1939 value of money. Thus, in paragraph 6 of their Report the Committee say: "At an early stage in our deliberations we reached the conclusion that we were not qualified as a Committee to form an opinion on what adjustment of immediately pre-war incomes was necessary to produce corresponding incomes to-day, and that the best course for us to pursue was to consider what incomes would have been satisfactory, for the purposes with which we are concerned, in terms of the 1939 value of money. Throughout this Report, our recommendations are, therefore, those which it appears to us would have been necessary for the purposes of our remit had we been reporting in 1939. We leave to others the problem of the necessary adjustment to present conditions, but we

would observe in this connection that such adjustment should have direct regard not only to estimates of the change in the value of money but to the increases which have in fact taken place since 1939 in incomes in other professions. In our judgment it is only if corresponding changes are made in the incomes of general practitioners that the recruitment and status of their profession will be maintained as against these professions."

The Position Since the Inception of the National Health Service

11. The National Health Service began on July 5, 1948. As regards England and Wales, the material statutory provision is section 33 of the National Health Service Act, 1946, as amended by section 10 of the National Health Service (Amendment) Act, 1949. Under this section it is the duty of each Executive Council constituted under section 31 of the 1946 Act to make arrangements with medical practitioners "in accordance with regulations" for the provision of general medical services in the area for which the Council is responsible. The terms and conditions of service of general practitioners in contract with Executive Councils are governed by the National Health Service (General Medical and Pharmaceutical Services) Regulations, 1948, S.I. No. 506 of 1948 (hereinafter called "the general regulations"), as subsequently amended. The original scheme of the general regulations (Regulation 22) was that regulations should determine the amount to be credited to each Executive Council for distribution among general practitioners. In practice, however, successive amendments to regulation 22 have left it for the Minister and the Treasury to determine what sum each Executive Council should receive.

12. As to Scotland there is separate legislation (the National Health Service (Scotland) Acts, 1947 to 1951) and a separate series of regulations made by statutory instruments. The Scottish enactments and the Scottish regulations are, however, similar in all material respects with those relating to England and Wales. Copies of the Acts, and of the general regulations, for both England and Wales and Scotland (including subsequent amendments thereto) are annexed as Exhibit B.

13. The Acts and Regulations therefore required that the Government should provide the necessary funds to enable the general practitioners engaged in the service throughout the whole of Great Britain to be properly remunerated. As stated in paragraph 4 above, the scope and range of that remuneration was to be that laid down in the Spens recommendations, after taking into account the adjustments referred to in paragraph 6 of the Spens Report, and this total remuneration is that required for the whole of England, Wales, and Scotland together.

14. At no time since the inception of the service have the Ministers and the general practitioners been in agreement as to the total sum so required. As will be seen below, the aggregate amount which has in fact been provided for each year up to now in respect of the total remuneration of the general practitioners in the service has been fixed by the Ministers themselves, and in the face of protests by the practitioners that such aggregate sum was inadequate and did not properly give effect to the Spens basis.

It is submitted, therefore, that the amount so fixed by the Ministers up to now can in effect only be treated as interim payments on account, pending the determination of what is the proper amount for each year; and it is because the two sides are in disagreement as to what the proper amount is that the present Reference has been ordered.

The present Reference therefore includes within its scope the determination of the size of the Central Pool for all years since the inception of the service.

15. When the Ministers came to fix their own figure they were able to use as a starting point (with the acquiescence of the general practitioners) certain conclusions reached by Professor Bradford Hill as a result of his inquiries. These were as follows:

- (1) That the gross professional receipts of those persons who were in general practice as principals before the war were £28.14m. per annum, of which £11.35m. was consumed by practice expenses, leaving a total net professional income of £16.79m.
- (2) That if recommendations Nos. (1) and (2) of the Spens Committee had been applied to these principals, their total net professional income per annum would be greater by £3.1m., and would accordingly have amounted to £19.89m.

The basis of these conclusions was that there were 17,900 of such principals in practice before the war.

16. The Ministers therefore had as a basis for their calculations the following two figures:

Estimated practice expenses	... ..	£11·35m.
Total net professional income, after adjustment as shown by paragraph 15 (2)	... ..	£19·89m.
Total	... ..	£31·24m.

The Ministers then agreed that, as required by paragraph 6 of the Spens Report, there had to be applied to each of the two basic figures above, a "betterment factor," to allow for changes in the value of money since 1939, and it is from this point onwards that serious disagreement between the two sides arose and still exists.

17. The betterment factor which the Ministers themselves applied to the estimated practice expenses was 55 per cent, and the betterment factor which they applied to the adjusted net remuneration was 20 per cent. The general practitioners allege that both these percentages are too low. The result of their application was, however, as follows:

"practice expenses" (£11·35m. plus 55 per cent)	... ..	£17·59m.
"net income" (£19·89m. plus 20 per cent)	... ..	£23·87m.
Total	... ..	£41·46m.

The figure of £41·46m. was then adjusted by adding 3 per cent, or £1·24m., to allow for the increase over the pre-war population. The resulting figure of £42·70m. represented, in a round figure, 18s. per head of the estimated population on June 30, 1948.

18. This capitation figure of 18s. per head has become the basis of what is now called "the Central Pool." Thus in each quarter of each year since the inception of the Service the Ministers have arrived at the Central Pool figure for that quarter by multiplying one-quarter of 18s. by a figure representing 95 per cent of the estimated population for the quarter. Such multiplier of 95 has been taken because the Ministers have assumed that in each quarter only 95 per cent of the population were actually at risk in the National Health Service and that the remaining 5 per cent would not avail themselves of that service, and would remain as private patients.

19. As a figure of the percentage of population not at risk it was agreed by both sides that 5 per cent was the right figure to take for the first two years of the service; but the general practitioners will in any case allege that this percentage has tended to decrease with the passing of the years, so that, at any rate for the year ended March 31, 1951, onwards, this percentage of 5 per cent is too high.

20. The Central Pool thus forms part of, but does not represent the whole of, the aggregate amount which has been paid out in each year by way of remuneration of general practitioners in respect of their National Health Service work; for in addition to the amount of the Central Pool the Ministers have also paid out certain other comparatively small sums which must be taken into account in arriving at the total health service remuneration for the year. These additional sums fall under the following heads (see the Sub-Appendix hereto):

- (a) An inducement fund.
- (b) Additional mileage payments.
- (c) Payments for maternity medical services.
- (d) Payments for the provision of drugs.
- (e) Payments for sight testing.
- (f) Training grants.
- (g) Payments from cottage hospitals.
- (h) Exchequer superannuation contributions.

21. For the year ending March 31, 1951, the Ministers, according to figures supplied by themselves, made the following payments to general practitioners in respect of their services under the National Health Service Acts:

	£m.
Central pool (after adjustment for the current population, based on 95 per cent of the total population) ...	41.533
Inducement fund	0.415
Additional mileage payments	0.500
Payments for maternity medical services	2.548
Payments for the provision of drugs	1.298
Payments for sight testing (estimated)	0.176
Training grants	0.385
Payments from cottage hospitals (estimated)	0.176
	<hr/>
Exchequer superannuation contributions	£47.031m. 2.274
	<hr/>
	£49.305m.

22. In order that proper use may be made of the figures supplied by the Ministers and set out in paragraph 21, the following facts are material:

- (1) Out of the sum of £47.031m. referred to in paragraph 21 the sum of £0.155m. was, according to figures supplied by the Ministers, paid out to general practitioners with restricted lists. These are general practitioners whose activities within the National Health Service are limited:
 - (a) to the provision of maternity medical services, or
 - (b) to the provision of supplementary ophthalmic services, or
 - (c) to the provision of general medical services for persons at particular establishments, e.g., the employees at a hospital or the pupils at a school.
- (2) The inducement fund payment mentioned in paragraph 21 is the only sum which has been specifically provided for the purpose of giving effect to recommendations (4) to (7) of the Spens Report. In determining what sum must be provided for the purpose of giving effect to recommendations (1) and (2) (the Central Pool), the sum of £0.415m. representing the inducement fund must therefore be left out of account.
- (3) Of the total sum of £49.305m. referred to in paragraph 21, only £47.031m. was actually received by the general practitioners concerned. Exchequer superannuation contributions are not to be included in gross receipts because, as explained in the Sub-Appendix, the doctor does not receive these contributions. Of the gross receipts of £47.031m., £0.155m. was, according to the Ministers' figures, received by the general practitioners with restricted lists, leaving £46.876m. as the gross receipts of the other general practitioners.

The Issues Between the Parties

23. The general practitioners accept the view that a satisfactory solution must have as its foundation the conclusions of Professor Bradford Hill which are set out in paragraph 15 above. In their application to each year of the service since its inception, however, it must be borne in mind that these conclusions are based on factors which will or may vary from year to year, namely, they were based on a doctorate of 17,900, they involve the question as to the proper ratio of practice expenses to gross receipts, or at any rate the range of such practice expenses, and the figures set out in paragraphs 15 (1) and (2) are of course stated in terms of the 1939 value of money, and adjustments must accordingly be made to allow for such variations. Further adjustments may also be required to allow for the rise in the incomes in other professions which may be found to have taken place since those conclusions were formulated.

24. So far as the Central Pool is concerned, the sums which have been allocated by the Ministers each year since the inception of the service do not adequately take account of all these variable factors.

Thus, in 1948, the Ministers arrived at the capitation payment of 18s. per head of population by the method set out in paragraph 17 hereof, that is to say, by adding the "betterment factors" therein set out, and by adding something to cover the increase in the pre-war population.

Even assuming that the quantum of those betterment factors was right, the result has been that in arriving at the amount of the Central Pool for each quarter of all subsequent years the Ministers have calculated it simply by multiplying that one-quarter of 18s. by 95 per cent of the total population of that quarter, so that the resulting total Central Pool figure of £x for any quarter is the amount divisible among the total number of practitioners in the service for that quarter, irrespective of whether that total number has risen or fallen in that quarter as compared with the 17,900 practitioners.

The only quarterly variation which this method covers, therefore, is the increase in the numbers of persons who in that quarter it is assumed will have been at risk in that quarter, which is arrived at by taking 95 per cent of the estimated amount by which the population will have increased in that quarter over the previous quarter.

The general practitioners allege, therefore, that the Ministers' method of arriving at the Central Pool each quarter fails to take any (or sufficient) account of the following matters, namely:

- (a) The increase in the number of practitioners engaged in the service in that quarter over the basic number of 17,900, and the necessity for seeing that each group within the increased number attains the required level of remuneration.
 - (b) The extent to which the "betterment factor" both in relation to required net income of the practitioners and to their practice expenses which was originally taken is either too high or too low for that particular quarter.
25. The main points upon which the two sides are at variance are therefore:
- (1) The amount of the "betterment" factor to be applied to the net pre-war incomes of general practitioners in relation to all years from the inception of the National Health Service, the pre-war basis being the adjusted net income of £19.89m. referred to in paragraph 16, hereof. Involved in this question is the extent to which the value of money has depreciated in the relevant years as compared with 1939, and the extent to which incomes in other professions have increased in relation to the pre-war incomes of those professions.
 - (2) The extent to which, in arriving at the net incomes of practitioners for the relevant years, practice expenses are to be allowed for, and the basis of the calculation of those expenses.
 - (3) The question as to whether the amount of the Central Pool for each year (or quarter) is to be ascertained by reference to the number of practitioners engaged in the service during that year (or quarter) instead of, as now, by reference to changes in the population.

In the event that the Central Pool is to be based on the number of practitioners instead of population, the question will then arise as to what is to be taken as the amount of gross receipts which the practitioners as a whole can look for from sources outside the National Health Service.

In dealing with each of these matters, it is proposed to use, for purposes of illustration, the year ended March 31, 1951, since this is the last financial year for which full information is available on all the relevant factors.

Betterment

26. It is possible to determine with reasonable accuracy:

- (a) the general level of earnings per head for all operatives in manufacturing and certain other industries, as compared with the general level per head of such earnings before the war;
- (b) the general level of net professional incomes per head, as compared with their general level per head before the war;
- (c) the general level of prices for wage earners, as compared with the general level of such prices before the war; and
- (d) the general level of prices for the upper middle class, as compared with their general level before the war.

In this context the expression "net income" is used to mean gross receipts less the amount allowable as deductions for expenses by the income tax authorities. No deduction is made for tax. The expression "net income," used in this sense, corresponds with the sense in which it was used by the Spens Committee as explained in paragraph 21 of their Report.

For the year ended March 31, 1951, the comparison is approximately as follows:

(1938=100)

- | | |
|-----------------------|-----------------------|
| (a) approximately 240 | (b) approximately 220 |
| (c) approximately 185 | (d) approximately 216 |

27. In the light of this information, the figure of £19·89m., representing the total net income which 17,900 practitioners should have attained in 1938, can be adjusted so as to give a corresponding figure of total net income for that number of practitioners for the present day. The least favourable basis for adjustment is to assume that the net income of general practitioners should increase in the same ratio as the net incomes of the professional class generally, and should not increase in the same ratio as the net incomes of the working class. On this basis, the increase above the figure of £19·89m., for the year ended March 31, 1951, is 120 per cent.

Practice Expenses

28. A sample survey conducted by the Inland Revenue showed that in the year ending March 31, 1950, professional expenses of general practitioners engaged in the service were 35·5 per cent of their gross receipts. (It should be observed in this connection that the expression "gross receipts" does not include Exchequer superannuation contributions, which, as explained in the Sub-Appendix, are not actually received by the practitioners.) The sample originally produced was so small, and so much smaller than that which the General Medical Services Committee had agreed to accept, that the Committee was not able to regard the percentage of 35·5 as a proper measure of the professional expenses for the year stated. In the discussion which ensued the Minister offered to take the figure of 36½ per cent but the Committee felt that 37½ per cent would be appropriate, though it offered unavailingly to compromise at 37 per cent.

More recently, the Inland Revenue have been able to produce figures based on a larger sample: the percentage shown is again 35½ per cent. The sample is, however, still small, and the General Medical Services Committee will contend that the correct percentage for the year ending March 31, 1951, is not less than 36½ per cent.

29. The Inland Revenue have also given comparative expense ratios for a small number of cases for the years ending March 31, 1950, and 1951 respectively. From this comparison it appears that in the year ended March 31, 1951, practice expenses absorbed a higher percentage of gross receipts, the increase shown by the figures supplied by the Inland Revenue being 2·2 per cent. It is known that the prices on which practice expenses are based have increased substantially since March 31, 1950. On the basis of the information available the General Medical Services Committee claim that the ratio of professional expenses to gross receipts for the year ended March 31, 1951, should be taken as being 38·7 per cent.

30. For the year ended March 31, 1951, the gross receipts of general practitioners from the National Health Service (exclusive of practitioners with restricted lists), can, as shown by paragraph 22 (3), be estimated at £46·876m. By applying the percentage of 38·7 per cent to the figure of £46·876m. it can be deduced that the professional expenses in respect of National Health Service work of practitioners engaged in the service, other than those with restricted lists, amounted to £18·141m.

Number of General Practitioners

31. Year by year it can be shown, or can be deduced with reasonable accuracy, how many general practitioners are engaged in the National Health Service. Although the number has always been in excess of 17,900, and is for the time being tending to increase, there is no question of the service being "overdoctored." Effective safeguards against overdoctoring are provided by section 34 of the National Health Service Act, 1946 (section 35 of the National Health Service (Scotland) Act, 1947), under which an application by a general medical practitioner to provide services under the Act in any particular

area may be refused by the Medical Practices Committee, on the ground that the number of practitioners undertaking to provide general medical services in the area is already adequate. Moreover, general practitioners as a class are harder worked at the present time than they were before the inception of the National Health Service Act.

32. The Adjustments referred to in paragraph 27 relate to 17,900 general practitioners. In the year ended March 31, 1951, the number of principals engaged in the National Health Service, excluding those with restricted lists, was approximately 19,227. Since there is not and cannot be a surplus of general practitioners in the National Health Service, it is obvious that the standard of net income envisaged by the Spens Committee can only be achieved if the total sum available to provide the net income of the general practitioners engaged in the service is adjusted in the proportion in which the number of those practitioners exceeds 17,900. In default of such adjustment, the funds available will not be sufficient to secure that each group within the increased number of general practitioners attains the required level of remuneration, thus securing the percentage distribution of remuneration required by the recommendations of the Spens Committee. Changes in population provide no criterion of the adjustments required in order to achieve the present purpose.

Practitioners with Restricted Lists

33. The foregoing calculations take no account of general practitioners with restricted lists, since the position of these practitioners is governed by special considerations.

On the basis of the available figures, it can be estimated that for the year ended March 31, 1951, the average number of general practitioners with restricted lists was 917. The gross receipts of those practitioners from the health service during that year are estimated by the Ministers to have been £0.155m.—paragraph 22 (1). The increased amount which these practitioners would have been entitled to for the year ending March 31, 1951, on the footing of the claim now put forward on behalf of the remaining practitioners, cannot at present be accurately computed, because the necessary data are not at present available to the General Medical Services Committee; but it is nevertheless claimed that they will be entitled to the appropriate increase.

Receipts from Sources Outside the National Health Service

34. It is not possible to obtain exact figures showing what remuneration is derived by general practitioners in the National Health Service from sources outside that service. The following matters, however, are relevant to this question:

- (1) It is apparent from an inquiry commenced but not completed by the British Medical Association that the number of general practitioners in practice who are wholly outside the service is in excess of 637. In addition there is a number of doctors who, though not classified as general practitioners for the purposes of the British Medical Association's register, do do a certain amount of general practice outside the service. No figures as to these doctors are at present available. Again, some further and at present unknown number of general practitioners with restricted lists in the service, engage in general practice outside the service. On a fair estimate it is probable that the total number of general practitioners who are outside the service, together with those who have only restricted lists in the service but who also engage in private practice, will eventually be found to be not less than 1,000.
- (2) There is only a small proportion of the population (which is at present estimated by the Ministers at 5 per cent) (see paragraphs 18 and 19 above) which is not likely to take advantage of the National Health Service.

35. It is apparent from the matters set out in paragraph 34 that the general practitioners outside the service must account for a large proportion of the patients who are outside the service. Moreover, it is on the whole the experience of those general practitioners who are inside the service that their receipts from sources outside the service are a small and declining factor. It is conceded, however, that some allowance must be made for this factor. Taking the year ended March 31, 1951, and excluding from consideration those general practitioners who have restricted lists, the General Medical Services Committee will submit that the total gross receipts of the general practitioners inside

the service from general practice outside the service are not likely to have been in excess of £1m. On the basis of the percentage for practice expenses referred to in paragraph 30 (38·7 per cent) this sum represents £0·387m. for practice expenses and £0·613m. for net income.

Determination of the Size of the Central Pool

36. The foregoing are the considerations which, in the submission of the General Medical Services Committee, are relevant to the determination of the amount necessary to give effect to recommendations (1) and (2) of the Spens Committee. In addition, a further sum must be provided each year, to give effect to recommendations (4), (5), (6), and (7). The amount of this further sum is not an issue in the present Reference, because its amount does not affect the size of the Central Pool.

37. The General Medical Services Committee therefore submit that for the year ended March 31, 1951, the amount of the Central Pool should be determined as follows:

CALCULATION OF THE SIZE OF THE CENTRAL POOL

(1) Net Pre-war Income of Principals in General Practice:

Net pre-war income of 17,900 principals in general practice (see paragraph 15)	£16·790m.
Increase required to the above net income, to give effect to the Spens Committee Recommendation that the proportion of practitioners able to reach, in the years 1936-1938, a net income of £1,300 or over was too low	£3·100m.
Net pre-war income, as accepted by the Ministry of Health, necessary to remunerate 17,900 principals in general practice so as to give effect to the improvements recommended by the Spens Committee	£19·890m.

(2) Net Income of Principals in General Practice Belonging to the National Health Service during the Year March 31, 1951:

Paragraph 27 shows that the level of professional incomes for the year to March 31, 1951, was 220 per cent of the level of professional incomes for the year 1938.

The net pre-war income shown in (1), £19·89m., should therefore be increased by 120 per cent to give effect to the Spens Committee Recommendation that the net income of general practitioners should keep pace with increases in the incomes of other professions since before the war in order that the recruitment and status of the medical professions should be maintained as against other professions.

The net income for the year to March 31, 1951, of the principals in general practice belonging to the National Health Service, assuming that the number of practitioners had remained unaltered since before the war, would therefore be 220 per cent of £19·89m. £43·758m.

It is estimated that the number of principals in the National Health Service (excluding those with restricted lists) during the year to March 31, 1951, was 19,227. The above amount of £43·758m., which is based on the net pre-war income of only 17,900 principals, should therefore be increased in the proportion of 19,227:17,900 in order that the standard of net remuneration per principal envisaged by the Spens Committee should be maintained:

$$\frac{19,227}{17,900} \times £43·758m. = £47·002m.$$

(3) Practice Expenses for the Year ended March 31, 1951, of all General Medical Practitioners in the National Health Service:

Gross receipts from all National Health Service sources for the year to March 31, 1951, excluding Exchequer superannuation contributions, for all principals in the National Health Service, including those with restricted lists (see paragraph 21)	£47·031m.
Deduct: Estimated remuneration of principals with restricted lists (see paragraph 22)	0·155m.

£46·876m.

Add: Estimated gross receipts for the year ended March 31, 1951, from professional sources outside the National Health Service, for all principals in the National Health Service, excluding those with restricted lists (see (5))	1·000m.
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Gross receipts from all professional sources for the year ended March 31, 1951, for all principals in the National Health Service, excluding those with restricted lists	£47·876m.
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For the year to March 31, 1951, the Association has estimated that the practice expenses of general practitioners in the National Health Service amounted to 38·7 per cent of gross receipts in that year.

Practice expenses at 38·7 per cent of £47·876m.	£18·528m
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(4) Gross Receipts of General Medical Practitioners in the National Health Services excluding those with Restricted Lists, for the Year to March 31, 1951, to give effect to the Spens Committee Recommendations would therefore be:

Net incomes (see (2))	£47·002m.
Practice expenses (see (3))	18·528m.
	£65·530m.

(5) Gross Receipts of General Medical Practitioners in the Service, excluding those with Restricted Lists, from sources outside the National Health Service for the Year to March 31, 1951:

—say £1·000m.

(6) Total Health Service Remuneration for the Year to March 31, 1951, for all General Medical Practitioners in the National Health Service, excluding those with Restricted Lists, required to give effect to the Spens Committee Recommendations

£64·530m.

(7) Add to (6) Total Health Service Remuneration of all General Medical Practitioners with Restricted Lists for the Year ended March 31, 1951:

Estimated receipts of General Medical Practitioners with restricted lists for the year to March 31, 1951 (see paragraph 22)	£0·155m.
The betterment factor to be applied to these receipts has been provisionally estimated at	0·050m.
	£0·205m.

(8) Total Health Service Remuneration for the Year to March 31, 1951, for all General Medical Practitioners in the National Health Service to comply with Spens Committee Recommendations should therefore have been

£64·735m.

- (9) Deduct from (8) receipts from National Health Service sources, excluding payments made from the Central Pool and the Inducement Fund for the Year to March 31, 1951:

	£m.
Additional mileage money	0.500
Maternity medical services	2.548
Drugs	1.298
Sight-testing	0.176
Training grants	0.385
Cottage hospitals	0.176
Exchequer superannuation contributions	2.274
	<hr/> £7.357m. <hr/>

- (10) The Central Pool for the Year ended March 31, 1951, should therefore have amounted to £57.378m.

38. The General Medical Services Committee will also ask the adjudicator to determine on similar lines the size of the Central Pool for the nine months ended March 31, 1949, and for the year ended March 31, 1950, and evidence will be made available to the adjudicator at the hearing to enable such determinations to be made. Such determinations are, for the reasons given in paragraph 14, an essential part of the present reference. Unless full effect is given to the Report of the Spens Committee on and from July 5, 1948, the Government's undertakings will remain unfulfilled and the general practitioners will be left with no remedy against the injustice which they have suffered as the result of the delay in giving full force and effect to those recommendations.

39. The size of the Central Pool for the year ending March 31, 1952, and for subsequent financial years should be calculated on the principles applied in paragraph 37 to the year ended March 31, 1951, with such adjustments as may be necessary:

- to allow for the total number of practitioners in practice in the year in question;
- to allow for changes in the value of money and their effect on the real net income of general practitioners;
- to allow for changes in the proportion of practice expenses to gross remuneration; and
- to allow for any further contraction in the receipts of National Health Service practitioners from private practice.

The general practitioners will ask the adjudicator to include in his award a finding that the size of the Central Pool for the year ending March 31, 1952, and for subsequent financial years should be determined accordingly.

Delivered the 21st day of February 1952 by Hempsons, solicitors to the General Medical Services Committee.

SUB-APPENDIX

REMUNERATION OF GENERAL PRACTITIONERS

Sources of Health Service Remuneration Additional to the Central Pool

The following are provided out of Exchequer moneys which are independent of the Central Pool:

1. Inducement Fund

This is a fund established for the purpose of making extra payments to doctors who practise in difficult and unpopular areas and also to meet cases of hardship where doctors have sustained a heavy loss of income as a result of the National Health Service. The award of payments from the Inducement Fund is made by Ministers after taking the advice of the Medical Practices Committee, constituted under section 34 (2) of the National Health Service Act, 1946, or as the case may be, the Scottish Medical Practices Committee constituted under section 35 (2) of the National Health Service (Scotland) Act, 1947. The amount of the fund has been fixed by the Ministers at approximately 1 per cent of the Central Pool.

2. Additional Mileage Payments

Mileage payments form part of the remuneration of general practitioners in rural and semi-rural areas. The major part of the sum necessary to make such payments is derived from the Central Pool, but it was from an early date recognized that the sum allocated for this purpose from the Central Pool was too small. Accordingly, an additional sum has been made available, and this additional sum is included in the total health service remuneration under the heading of "Additional mileage payments."

3. Payments for Maternity Medical Services

These are payments to general medical practitioners for maternity medical services provided by them under the National Health Service Acts. A general practitioner under his terms of service is not obliged to provide maternity medical services for the patients on his list except in cases of emergency.

4. Payments for the Provision of Drugs

These are special payments made in respect of drugs and dressings which a general practitioner is required to supply in an emergency, and in respect of drugs and dressings which a general practitioner dispenses or provides by arrangement with the Executive Council. These payments include two elements:

- (1) a fee for the services rendered by general practitioners in providing the drugs and dressings; and
- (2) a payment for the actual cost of the drugs and dressings supplied.

The figures supplied by the Ministers do not distinguish between these two elements.

5. Payments for Sight Testing

These are payments made to general practitioners who provide supplementary ophthalmic services by arrangement with Executive Councils under section 41 of the National Health Service Act, 1946 (section 42 of the National Health Service (Scotland) Act, 1947).

6. Training Grants

Included in these payments are a training fee of £150 a year for the principal, and a sum in respect of the emoluments of the assistant. The figures supplied by the Ministers do not distinguish between these two elements.

7. Payments from Cottage Hospitals

These are payments in respect of general medical services provided by a general practitioner as a member of the staff of a hospital. Such general medical services may be provided by a general practitioner either (a) as one of the staff of a "cottage" hospital, or (b) as a part-time medical officer of a convalescent home or other institution.

For this work the practitioner is remunerated by the Hospital Management Committee, or, in Scotland, the Hospital Board of Management. The expenses of the Committee or Board are borne by the Exchequer.

8. Exchequer Superannuation Contributions

General practitioners in contract with Executive Councils are superannuable under the National Health Service (Superannuation) Regulations, 1950 (S.I. 1950, No. 497), and under corresponding Regulations relating to Scotland. Under the scheme of superannuation comprised in these Regulations, contributions are payable both by the practitioner and by the Executive Council. The amount of the contributions is based upon the practitioner's remuneration, which for this purpose means all payments made by the Council to the practitioner in respect of general medical services provided by him, less a sum in respect of practice expenses which is determined in accordance with a formula laid down by the Government. The Executive Council's contribution amounts to 8 per cent of the doctor's remuneration, as so determined. This contribution is provided out of Exchequer moneys which are separate from the Central Pool. It is counted as part of the practitioner's "remuneration," although, of course, it is not in fact paid to him but is set aside for the purpose of providing superannuation benefits. It does not therefore form part of the practitioner's actual receipts.

APPENDIX XI

CALCULATION OF GENERAL PRACTITIONER REMUNERATION
AND THE CENTRAL POOL

General practitioner remuneration is calculated on the basis of the net remuneration appropriate for general practitioners in 1939 (as recommended by the Spens Committee in 1946) together with a betterment factor taking account of changes in the value of money up to 1951. This amount is then adjusted to take account of changes in the number of general practitioners participating in the Service and their estimated practice expenses. From this global sum is deducted the estimated remuneration of general practitioners from all other sources (including Private Practice) and the superannuation contributions made by the Exchequer. The sum remaining represents the Central Pool.

The Central Pool is calculated provisionally at the beginning of each financial year and from it the following payments are made:

Capitation fees and loadings.	Temporary resident fees.
Initial practice allowances.	Emergency fees.
Supplementary annual payments.	Anaesthetic fees.
Mileage payments.	

After the payments which are derived from the Central Pool have been made, any balance of money due when the Pool is finally calculated after the end of each financial year is distributed to doctors in proportion to their respective earnings by way of capitation fees and loadings. This residual payment is normally made some eighteen months after the end of the financial year in question. No interest is paid on the sums outstanding.

The following statement showing the calculation of the Central Pool for the years 1953-54 and 1954-55 shows (a) the method of calculating the required global sum; (b) the various sums which go to make up this overall total; (c) the amount of the Central Pool; and (d) the method by which the final settlement moneys (i.e., the balance of the Central Pool due for each year) are determined.

	1953-54	1954-55
Number of doctors with unrestricted practices ...	20,650	21,133
	£m.	£m.
Required total net income at £2,222 per doctor ...	45·884	46·958
Practice expenses ...	20·657	23·549
Required total gross income (i.e., global sum) ...	£66·541m.	£70·507m.
Actual remuneration received:	£m.	£m.
Central Pool (capitation fees and loadings, initial practice allowances, supplementary annual payments, mileage payments, temporary resident fees, emergency fees, anaesthetic fees) ...	52·068	52·898
Maternity services ...	2·790	2·842
Drugs ...	1·794	1·797
Training grants ...	0·393	0·393
Sight testing ...	0·090	0·092
Fines ...	0·003	0·002
Part II services ...	1·312	1·427
Local authorities ...	0·622	0·623
Government departments ...	0·840	0·756
Private Practice ...	2·000	2·000
	61·912	62·830
Less: Paid to doctors with restricted lists ...	0·100	0·102
	61·812	62·728
Exchequer superannuation contributions ...	3·195	3·422
Amount set aside for group practice loans ...	0·100	0·100
	£65·107m.	£66·250m.
Balance due to bring the Central Pool up to the required level for the year ...	£1·434m.	£4·257m.

Examination of Witnesses

DR. S. WAND, *Chairman of the Council*

DR. A. B. DAVIES, *Chairman, General Medical Services Committee*

MR. T. HOLMES SELLORS, *Chairman, Central Consultants and Specialists Committee*

DR. A. MACRAE, *Secretary*

DR. D. P. STEVENSON, *Deputy Secretary*

PROFESSOR R. G. D. ALLEN

MR. S. B. R. COOKE, *Counsel*

MR. N. LEECH TAYLOR, *Solicitor*

DR. L. S. POTTER

on behalf of the British Medical Association
Called and Examined

1116. *Chairman:* Dr. Wand, you will be acting. I take it, as the principal spokesman for the B.M.A. this morning?

—*Dr. Wand:* Yes.

1117. As to procedure I would like to say to you as we have said to others who appeared before us, that we will have to test what you say as to facts thoroughly and therefore we will have to ask you to justify such statements as we wish to press. That does not imply either disbelief or hostility, but if we do not test these statements no one else will. On the other hand, failure to pursue a subject in the evidence you have submitted to us does not necessarily imply either its acceptance, or that we regard it as irrelevant.

I would add that there are quite a number of important points that we do not intend to pursue at this stage because you have told us you will be giving special memoranda covering those particular topics at a later stage; we would prefer to pursue them then. On those points we would not expect to touch more than generally, if at all, at this stage, and I feel sure that will be in accordance with your own views?—
Yes, Sir, I agree.

1118. Any member of the Commission will of course have a chance to ask questions of you, but for convenience we have given the task of sifting the very many written submissions that we have received to two sub-committees. In this particular case Sir David Hughes Parry has acted as Chairman of the Sub-Committee and so he will be leading off with most of the main questions.

I think I should also say, with most of the bodies that have submitted

evidence to us, that some of the evidence at least is of great interest but strictly outside our terms of reference. We may well be asking some questions on some matters that are submitted, in order to get the general picture built up; but we will not by any means necessarily be making any reference to those matters in any report that we may eventually submit.

Might I start, before handing you over to Sir David, by asking, largely for the record, about your constitution and coverage of the medical profession? If you could say a few words on how many you represent, how you are voted to become representatives, that would be useful.—We represent all doctors engaged in the National Health Service. As an Association we have a membership of over 70,000 and of that 70,000 we have some members overseas. Of the practising profession in this country 80 per cent. are members of the Association. But in addition to that we have an organisation which allows full representation of all those engaged in the National Health Service in the various spheres, even although they are not members of the Association, that is to say through the General Medical Services Committee on the general practitioners' side, and the Consultants' and Specialists' Committee on the specialists' side.

Each of those bodies is fully representative and in the case of the General Medical Services Committee there is also an annual conference of Local Medical Committees which represent all the general practitioners in the different areas. They can send up to the con-

ference and to the General Medical Services Committee doctors who are not members of the Association.

On the consultants' and specialists' side there is a similar organisation but it is regional. There are regional Consultants' and Specialists' Committees representative of all levels of hospital doctors, and they in their turn send representatives to the Central Consultants' and Specialists' Committee. In its turn it forms part of the Joint Committee with the Royal Colleges and the Scottish Corporations.

It is a little involved but through this machinery we can get the views of every single doctor in the National Health Service.

1119. The Consultants' and Specialists' side really is what you might call the hospital service side, right down to the earlier stages in the career?—Yes. We have in addition groups of various specialties within the Association, groups with particular interests, and they can express the views of the group through the Central Consultants' and Specialists' Committee—for example, radiologists, pathologists, psychiatrists—every specialty more or less that is narrower than the general field of medicine or surgery; and there is also the Senior Hospital Medical Officers' Group, and a group for Registrars.

In other words we have tried effectively at all times since the National Health Service came into existence to get the whole of the views of the whole profession available through any possible channel that they may decide.

1120. Would there be a separate organisation for those who are not—as you are aware—within our terms of reference; and that is the local authority people, the Medical Officers of Health?—We have a Public Health Committee within the Association representative of all Public Health Medical Officers. We hope at a later stage to present a memorandum from that Committee. There is representation on that Committee of the Council of the Society of Medical Officers of Health.

1121. On the general practice side, are you representative of the assistants?—Yes, we have a special sub-committee of the General Medical Services Committee, democratically elected and

representing assistants and what we call unestablished practitioners.

1122. So that on each side there is opportunity all the way down for views to be represented?—Yes.

1123. And that is your claim?—Yes.

1124. Would you care just to say a word about your relationships with some of the other bodies representing the profession? You know we have already seen the Medical Practitioners' Union, the Socialist Medical Association—which is perhaps rather separate—and we will be seeing the General Practice Reform Association. Could you in just a word say what the relationship is between them and you?—With the two latter bodies we have no relationship. With the former body, the Medical Practitioners' Union, we have two of their representatives nominated to the General Medical Services Committee; they are ex-officio members.

1125. And there would be a considerable duplication of membership?—There is a considerable duplication of membership. I use the word "considerable" as a percentage rather than in terms of actual numbers.

Chairman: I think those are all the points I wish to ask at this stage on your—as one might say—qualifications to represent the doctors as a whole, Dr. Wand.

1126. *Sir David Hughes Parry:* You say, Dr. Wand, in paragraph 5 of your preliminary memorandum that you are able to speak with broad authority on behalf of members of hospital medical staffs and all general practitioners on the matters now under review. What you really mean is that you are a democratic body acting by a majority vote?—That is so.

1127. You do not claim to speak for every member of the Association?—Every member of the Association and every member of the hospital staffs and every general practitioner engaged in the general medical services has an opportunity, through local meetings, to express his views, which will be expressed again through the conference of Local Medical Committees and the Regional Consultants' and Specialists' Committees, and ultimately it will be considered here in London at the pinnacle.

1128. But if his individual view differs from the view of the majority, it is the

view of the majority that is expressed here?—Yes.

1129. You are a democratic body?—We are a democratic body.

1130. Dr. Wand, I think our best plan will be to work on your preliminary memorandum of evidence, if you agree, and I would take you straightaway to paragraph 12. We as a Commission issued a statement on the 12th April, 1957. What we said in that statement was that the Spens Report and the Danckwerts Award will be studied by the Commission; the Commission thinks it will be advantageous if we study them together this morning.

Can we take first of all the terms of reference of the Spens Committee on the Remuneration of General Practitioners. The only question that is contained in the terms of reference is what ought to be the total range of professional income of a general practitioner in the public health service. That is the only question put to the Spens Committee. Then the Committee was asked to have regard to two matters in particular, the normal expectations in the past, and secondly, the desirability of maintaining in the future the proper social and economic status of general practice and the power to attract suitable recruits.

Shall we take the first of those things to which regard was to be had—normal expectations in the past? You base your case almost completely on certain figures as to the remuneration of general practitioners from all sources, supplied by Professor Bradford Hill, do you not?—Yes. That was the basic figure from which our case stemmed, but behind it all was a letter from the Ministry, prior to the setting up of the Spens Committee. The Ministry consulted us. The Ministry said in a letter that it was essential to the success of the whole undertaking—that was the inquiry of the Spens Committee—that the whole membership of the Committee should be acceptable both to them and to us; they discussed with us the Committee's membership and the terms of reference.

But in the first part of this letter there was a statement that future arrangements between the profession—may I just go back on two or three words to get the sense more clear—"... in co-operation with the Committee which would arrive at useful general standards on which future arrangements between

the profession and the Minister could be confidently founded". The foundation was to be Spens. The Bradford Hill figures were presented as showing what had happened in the past, and of course it was part of our case to Spens to show how the remuneration of doctors in respect of their National Health Insurance patients was inadequate. In point of fact Spens found that it was inadequate to the extent shown in their Report, and had in fact been inadequate over a considerable time in the past.

1131. Thank you. I wanted to make it quite clear that the recommendations were in the main based on the Bradford Hill figures. Can we proceed to these recommendations straightaway? There were seven of them, were there not?—Yes.

1132. The first one outlined a scheme to be devised to ensure certain ranges of remuneration of general practitioners—that was the principal one, was it not?—Yes.

1133. It was made quite clear at the end of the description of the scheme that they were expressing their recommendation in terms of the 1939 value of money. That was the first one. The second one and the fourth, I think, deal with certain loadings, certain adjustments that were to be made in these ranges. I understand that the ranges indicated by the Bradford Hill figures were regarded as too low; that is right, is it not?—Yes.

1134. General practice at that time was in part competitive and in part based upon the panel, was it not?—They were both competitive in the sense that they were independent. The panel was not a full time service or anything of that kind. It was the method of payment that was different. One was paid by items of service, by arrangement between the patient and the doctor, and the other by capitation fee, an arrangement between the government and the doctor.

1135. The point I want to make quite clear is that the earnings in general practice before 1939 were ascertained through Professor Bradford Hill's figures, and certain adjustments, loadings or additions were made to them by the Spens Committee; that is right, is it not?—Yes.

1136. That deals with the first consideration, that due regard is to be had to the normal financial expectations of

general medical practice in the past. For the future certain additions were to be made to them?—That is so.

1137. Again in No. 5 and No. 6, suggestions were made for certain adjustments or loadings to be made, were they not?—Yes.

1138. I just draw attention to these because I want to deal with some of them at a later stage. Shall we deal now with the subject of the implementation of each one of these recommendations how far they were in fact implemented? I would like you to take each one of them separately and deal with it in your own way, No. 1 first.—I will do my best, though I am not quite clear how far you want me to go.

1139. If you would deal with them rather generally at this stage.—I do not know whether I made myself quite clear when I answered your first question which contained the word "competitive". I think it is quite clear in the Spens Report that the difference, in financial terms, between the two kinds of practice before the Report was implemented was that stated somewhere in the Report. Doctor witnesses indicated they were doing two-thirds of their work for their insured patients and receiving only one-third of their remuneration from those same patients; and it was in that field that Spens was asked to rectify matters. There was competition in so far as the patient had exactly the same or practically the same choice of doctor as with the private practitioner. It was, as I said, only a matter of difference of payment.

In the Spens Report, coming back to this question, it is made clear that in a National Health Service there would be some greater evenness of income than had occurred prior to the National Health Service. It was thought a National Health Service would inevitably produce a greater evenness of income. I think you have to look at these various recommendations in broad bands. In the Spens Report you will find that an income distribution is set out. Table B for example refers only to the age group, 40-49. But shortly afterwards in the Report in paragraph 11 they make it clear that they are not committed entirely to that particular age group for that particular distribution. They do in fact go right back to the age of thirty. I have no

figures at all and I do not think any are available to show what the precise banding of practitioners' incomes is at the moment, but the average list for each practitioner in the country is roughly 2,500. You will find that if you take the table which shows the distribution of the money that goes into the global sum, roughly a 2,800 list today will produce round about £2,400. In the first Spens recommendation you will see that the £1,200 margin—which with a 100 per cent. betterment comes to £2,400—is to be exceeded by roughly 60 per cent. of the doctors within certain age groups. Whether that has been implemented or not I do not know.

You will see also that it was indicated by Spens that a small proportion of doctors should be able to earn net incomes of over £2,500. That was at 1939 values. In paragraph 14 were set out some suggestions to try to enable this to be done. These suggestions have only in a very modified way been carried out and indeed, Sir, the suggestion contained at the bottom of page 9 has been carried out in a different way. I have been at some pains lately to try to find out if the £3.1 million—which was the addition agreed with the Ministry in order to implement the recommendations of Spens at 1939 values—did include the suggestion made at the bottom of page 9 and I have not been able to find that it was so included. Although the amount of money paid to training practitioners—nearly £400,000—has in fact come out of the pool, it would appear from recommendation 1 that it should be extra, outside the pool. I do not know what other comments I can make on this.

1140. In other words, you find it very difficult to say, as anybody would, that recommendation 1 has been implemented?—In detail—but it has been implemented in total up to March, 1951. That is in betterment terms of that time. It has been implemented in total. The difficulties of precise implementation have been evident but in broad bands it may be found that the intention of Spens has been carried out. I do not know until we get figures.

1141. Every effort has been made to carry out the first recommendation?—Every effort has been made to see that there is available for distribution amongst the doctors the adequate sum of money to provide for these recommendations;

and the profession itself has done its best, including the Working Party after Danckwerts, to ensure an equitable distribution of those monies.

1142. *Chairman*: I would like to ask you a few more questions about that, Dr. Wand, because this is a very important recommendation of Spens and therefore one to which you attach a great deal of importance as to whether it has been carried out. It starts off—a scheme devised to ensure that between forty and fifty years of age approximately 50 per cent. of G.P.s receive net incomes of £1,300 or over, and which will also secure, so far as is practicable, that between forty and fifty years of age approximately one-quarter receive net incomes of £1,600 or over, and so forth. Was a scheme ever devised that was expected to ensure those particular things?—No, Sir, but you will see in paragraph 11 that Spens indicated quite clearly that those age groups were not to be regarded as the only groups in which a similar scheme would apply. And in another part of Spens you will see that it was expected that there would be some alteration in the precision of this table when a National Health Service was inaugurated.

1143. Yes, I realise the second recommendation dealt with other ages and I realise also it would be very difficult to be precise: but was a scheme ever devised, so far as you know, that was intended to give effect to this No. 1 recommendation?—No precise scheme.

1144. Do you think there ought to have been a scheme? Is it the B.M.A.'s position that a scheme ought to have been devised to give effect to this recommendation?—*Dr. Stevenson*: In paragraph 19 of the Spens Report there appears the statement that an estimate is made of the cost of the proposals in this Report which must be broadly assumed to be those concerning the range of remuneration, or the broad bands to which Dr. Wand referred. It is true that the figure of 15 shillings is quoted there as an attempt to estimate the cost of this scheme. That figure was of course a basic figure on which the capitation fee for the N.H.S. was based, so to the extent that Spens was right in saying this can be done there is an inference that the scheme introduced in 1948 had that function.

1145. *Mr. Gunlake*: Dr. Stevenson, the Working Party contained representatives of your own General Medical Services Committee. What attempt did it in fact make to see that this particular Spens recommendation as to bands of income was carried out?—*Dr. Wand*: The Working Party had certain specific terms of reference which were decided by the Ministry.

1146. *Chairman*: I think, Dr. Wand, the terms of reference of the Working Party are stated to be the agreed terms of reference.—They were agreed, but it was a condition of the Danckwerts Adjudication that the Working Party was set up.—*Dr. Stevenson*: The terms of reference were agreed on the understanding that certain things would be done, one of which was to restrict our unduly large lists.

1147. The question remains, did the Working Party with its own terms of reference try to carry into effect this first recommendation of Spens? We are trying to deal with the recommendations one at a time.—*Dr. Wand*: The Working Party was set up because the Ministry indicated, before the claim went to Mr. Justice Danckwerts, that such a body would be appointed to look at certain points which were set out in its terms of reference, and its terms of reference were limited.

1148. The first part of the terms of reference was to secure an equitable distribution of the central pool, based upon the recommendations of the Spens Committee. That is the point I am trying to get at. Was a scheme ever devised to carry into effect No. 1 recommendation of the Spens Committee, by the Working Party or at any other time?—No. The Working Party had very definite terms of reference. I have them now before me.

1149. The first line I think is part of it—to secure an equitable distribution of the central pool, based upon the recommendation of the Spens Committee.—*Dr. Stevenson*: I think, in so far as the 1948 calculation of 15 shillings related to paragraph 19 of Spens, so did the Working Party in 1952 attempt to relate an increase in capitation to the 15 shillings, based on a larger pool.

1150. I appreciate that. I am trying to find out whether there was an effort made to obtain the distribution among

general practitioners broadly indicated by Spens.—*Dr. Wand*: There was no attempt to get percentages. The Working Party concentrated on what had been in the Minister's mind—obvious at the time this was debated—on the second part of the terms of reference, to bring about a relative improvement in the position of those practitioners least favourably placed under the present plan, to make it easier for those doctors to go into practice, and so on. They concentrated on that, and that was the main contention of the Minister in our discussions with him. You will see that the Report is practically attached to those points.

1151. But you are anxious there should be a proper implementation of the Spens Report. That is fundamental to your case? Is it fundamental to your case for instance that the first recommendation of the Spens Report for general practitioners should be implemented? I think you said before that nobody knows whether it has been or not, until we get the figures. It may in fact have been; but I gather no scheme was ever devised that was really intended to put that into effect. Is that right?—Yes. Our purpose was to see there was an adequacy of money in the pool to enable the broad banding of Spens to be achieved. We do not know whether it has been achieved.

1152. If it has not been achieved, if the figures show that, is it your case that the spread shown in the first recommendation of Spens should be achieved?—Broadly the answer is one of distribution, and I think you can say our purpose is to see that there is a fair distribution.

1153. But do you regard the distribution suggested by Spens in his first recommendation as being the fair distribution you want?—We regard it as being a reasonable distribution at which to aim. But in a form of practice in which there must necessarily be changes from day to day, or month to month, in the size of list of an individual doctor, it would be impossible to achieve a precise figure of this kind; as indeed the Spens Committee indicated on page 9:

"We anticipate that the general introduction of a publicly organised service would of itself level up low incomes to a considerable extent."

This would mean that the precise implementation of Table B was not expected by the Spens Committee once we had got a publicly organised service.

1154. This first recommendation on distribution by Spens would have resulted, if it was implemented, in a levelling of remuneration to some extent. I think that is quite precise from the footnote.—In Table B the levelling is that 7 per cent. would have under £700, that 9 per cent. would have over £2,000, but that there would be a big band in the middle as between £700 and £2,000. Our knowledge of the size of lists today is that we have got that big broad banding in the centre.

1155. Would you agree, *Dr. Wand*, that the notes to that No. 1 recommendation read:

"The above proposal is approximately equivalent to the augmentation of net incomes in 1939 by £200 in the case of incomes between £400 and £1,200 and, in the case of incomes over £1,200, by £200 at £1,200, diminishing progressively to nothing at £2,000."

which must mean a levelling, and:

"We say nothing about reducing the high percentage of incomes below £700 since this would follow automatically from the operation of these recommendations."

which must mean a process towards levelling? I thought you had said that before. I could not quite see why you were doubtful. It was the object, was it not?—Yes. The object was to produce some levelling.—*Dr. Stevenson*: I think an attempt was made in 1948 to implement the distribution in Recommendation 1. But in 1952 the attempt was somewhat modified because the terms of reference of the Working Party which, though agreed were very much determined by the Minister, did in fact modify them. So far as the future is concerned—which I think is the point of your question—if the total amount was right, then I would say no-one would dispute that the distribution as laid down in Recommendation 1 would be quite acceptable, if it could be done.

1156. Nobody knows at present the extent to which that has been done; but when the B.M.A. say that a proper implementation of the Spens Report is fundamental to their case, are they

really including Recommendation 1 as part of that?—We must do.

1157. You want that distribution?—*Dr. Wand*: Approximately.—*Dr. Davies*: As far as it is consistent with our other obligations in distribution matters.

1158. I do not know what that means.—*Dr. Wand* and *Dr. Stevenson* have already referred to the remit to the Working Party. At the setting up of the Act there was a requirement of the Minister about distribution of patients among doctors, which led to the setting up of the Medical Practices Committee. That is an example of one of the obligations on distribution.—*Dr. Stevenson*: Sir Harry, I wish it to be quite clear that we have accepted the Spens Report. We have never disputed any part of it; therefore the answer must be that we stand by Recommendation No. 1. It is part of the Report we accepted and stood by.

Chairman: I think it would be better to come back later in the day to how best that distribution can be achieved.

1159. *Sir David Hughes Parry*: May I just ask one question on that? You did say you have no figures and it has been extremely difficult to see whether in fact the general design or effect according to Spens has been achieved. We hope, as you know, from the replies to the Commission's questionnaire, to be in a better position to judge that position. You realise that, do you not?—Yes.

1160. That is the main object of the questionnaire being sent out. May we take Recommendation No. 2: "Before 40 and after 50, practitioners should be remunerated at the rate applicable between 40 and 50 to the burden and responsibilities of practice which they are in fact carrying." Have you any suggestion to make as to the implementation of that?—*Dr. Wand*: It simply means if a doctor is able, energetic and so on before forty or after fifty, the same factors apply.

1161. *Chairman*: I have never entirely understood what that recommendation meant in detail, but I think it is quite clear that it goes with No. 1 and until we know the extent to which No. 1 has been carried out we cannot know the extent to which No. 2 has been carried out.—I think the meaning is

this. The Spens Committee attached themselves to a method of distribution which they said applied to a particular age group; but then they went a bit further and said "although we have done this, we do realise that many doctors are able to attract patients and do a first-class job of work and are energetic above the age of 49 and below the age of forty; like and like should be treated in the same way."

1162. And in fact the capitation fee system has never differentiated for age?—No.

1163. *Sir David Hughes Parry*: I will take Recommendation No. 3.

"In securing the above results, a method of differentiation of income should be chosen which will command so far as possible the confidence of the profession."

Has that been implemented?—Yes. We have always been willing to engage in discussions with the Government with regard to distribution and we would continue to do so. The Working Party report was submitted to our representative bodies in order that they might have an opportunity of opposing them or modifying them, and it was after their agreement that these new distributions were set up.

1164. Then so far as the B.M.A. is concerned, No. 3 has been implemented to the full?—Yes.

1165. *Chairman*: Except that we do not know whether it secured the above results. That we shall have to find out.—The profession was satisfied it gave the right numbers in the right places.

1166. The recommendation says "in securing the above results".—We do not know.

1167. *Sir David Hughes Parry*: The Working Party were directed to that end very largely? Their whole object was to try to carry out these recommendations?—Yes.

1168. Take Recommendation No. 4:

"The difference which has existed between the incomes of rural and urban practitioners should be reduced, the Highlands and Islands Scheme should be applied to other sparsely populated areas and the remuneration under that scheme should be increased."

What has been done to implement that?

—*Dr. Davies*: There is a special scheme of inducement payments for areas of sparse population such as the Highlands and Islands and certain pockets in England and Wales. That in effect is a subsidy to enable medical practitioners to provide services in areas which could not be adequately remunerated by any other method. As regards the truly rural practitioner, there is a special difficulty there in that the scope for large lists is somewhat limited and, taken into consideration with the fact that travelling long distances is time-consuming, we have thought it necessary to provide some compensation for that loss of time and consequent loss of income. Therefore in agreement with the Government a mileage committee was set up and it has made recommendations to provide a special mileage payment to rural practitioners.

1169. The object being in effect to implement this fourth recommendation?—That is so.

1170. But again we do not quite know how far this has been achieved?—*Dr. Stevenson*: I think we do because, as I see it, this recommendation was to help the position of the rural practitioner. Between 1948 and 1952 the size of this particular fund, which is to compensate the rural practitioner for his disadvantages, was increased from £1.3 million to £2 million, so I think one can say this has been implemented.

1171. In full?—Yes.—*Dr. Wand*: And a special mileage committee is considering a redistribution of this sum of money because of course you will realise that changes have taken place; what was previously a difficult rural area may have become a township and so on.

1172. *Sir Hugh Watson*: That matter is under review at the moment, *Dr. Wand*, is it?—Yes, and an interim report has indeed been issued.

1173. From what *Dr. Davies* said about the inducement areas, I gather you referred to really sparsely populated areas?—*Dr. Davies*: That is so.

1174. *Chairman*: The fourth recommendation reads: "The difference which has existed between the incomes of rural and urban practitioners should be reduced . . ." Apart from the sparsely populated areas to which you refer, has that recommendation been implemented?

—Yes, as far as the classification of areas goes, by this mileage committee's recommendation.—*Dr. Wand*: The mileage fund is not a flat rate through the country, per mile. There are loadings according to the type of country in which the doctor practices. In that way you get differentiation as to the proportion that comes from the mileage fund to a particular doctor or a particular area. It is relevant to the terrain he has to deal with. Obviously a doctor who has to go to a lighthouse will get a different payment—that is an *ad hoc* payment—from that of a country doctor who has to go over some flat easy country.

1175. What was the relationship, roughly—between the rural practitioners and urban practitioners in 1939?—In what sense, relationship?

1176. The recommendation says it should be reduced. I see we got it in Tables 1 and 3 of Spens. Take the age 45-54 group: am I right in thinking the difference was at that time about £220 on the gross income?—The figure as given in Spens, I think, is the nearest approach that has ever been made to that difference. In point of fact soon after the Service was inaugurated it was realised by us that this differential was not being adequately reduced. We met the Ministry and an agreement was made to take an additional £700,000 in order to provide for this. I think most of us felt at that time at any rate that we had solved a financial problem with that sum of money.—*Dr. Stevenson*: If it would be of any help, when Professor Bradford Hill and the Government Actuary calculated the £3.1 million, which was the deficiency, they based it on an agreed figure in order to bring the rural nearer to the urban. There was an addition of £11 per doctor to be added to the sum, so there is an actuarial figure which can be got on that question.

1177. The Medical Practitioners' Union's evidence—I suspect there was a misprint there—refers to the rural practitioner earning more than the urban one. I rather think they meant before the war.—I think the 1952 Ministry tables—the ones discarded and not published which attempted to show distribution—showed that the net remuneration of the rural doctor had gone a little too far and might even be in excess of the net remuneration of the urban doctor. That

was the reason for the establishment of this mileage committee who were to look into the whole question of distribution to see how far this had gone.

1178. *Professor Jewkes*: You mean the inquiry conducted for the purpose of establishing an expenses ratio?—I beg your pardon. It was a 1949 table, not that one. It was a famous Blue Book.

1179. I suppose we will have to wait for fuller figures, but the odd thing is that from the expenses ratio enquiry in 1952-53, once again the rural practitioner seems to be earning more than the urban.—*Dr. Davies*: In certain categories, Professor. The difference is quite marked at some levels, but it does not show that feature throughout the whole range. The largest expense ratio is in the small list group; but the difference when it occurs is approximately of the order of two per cent.

1180. But there are groups where the rural practitioner is earning more?—That is so.—*Dr. Wand*: You do get in the country the isolated instance of a moderate-sized conurbation surrounded by absolutely open country—rather like those villages in the valleys in France, nothing round them for a long way. In that type of area you get a fair number of patients in the conurbation but large distances to travel to patients who cannot get doctors from any other place than this town. There you are likely to get an increase of remuneration and so on.

1181. *Sir David Hughes Parry*: It would be fair to say an attempt has been made, on the Government side and on the side of the profession, to implement to the full Recommendation No. 4?—*Dr. Stevenson*: Yes, and this is still being done.

1182. But it may not be as ideal as one would like it to be, is that right?—*Dr. Wand*: This new inquiry I spoke of a moment ago will, we hope, make it even more accurate in terms of mileage distribution—fairer, shall I say, rather than more accurate.

1183. *Chairman*: The present difference based on the mileage as between what is an urban and what is a rural practitioner is generally accepted?—Yes. If I may use the words 'rural practitioners' fund' rather than mileage fund, it will indicate more precisely the objects of this fund. It is to deal with the prob-

lems of rural practice, not the narrower field of mileage alone.

1184. At any rate the B.M.A. accepted and still accept that the distribution as between rural and urban before the war needed altering so as to make them rather more even?—Yes.

1185. And are helping to take steps to put into effect this particular recommendation?—Yes, Sir.

1186. *Sir David Hughes Parry*: May we take Recommendation No. 5?

"Additional remuneration should be given in areas which prove so unattractive as not to draw an adequate supply of practitioners."

—*Dr. Stevenson*: I think one can claim that has been implemented.

1187. In what way?—Because there is a special inducement fund set up in 1948 from which payments are made to supplement the income received by general practitioners in certain areas who would otherwise find it economically impossible to practise in those areas. I suppose that this particular scheme, which was very necessary at the beginning, has been more widely used in Scotland and particularly in the Highlands and Islands. Up there, where it would be impossible for a doctor to gain a full competence, there is provision to supplement his normal income and so induce him to stay in the area. I think one can say this has been implemented.

1188. *Chairman*: Would you say, Dr. Stevenson, there are still districts under-doctored for economic reasons, or is the geographical distribution now right as a result of the operation of the scheme?—I think that Recommendation 5, Sir, was not designed to cover an equitable distribution in the way you put it.

1189. I meant, to draw an adequate supply of practitioners. The recommendation was that additional remuneration should be given in areas which prove so unattractive as not to draw an adequate supply of practitioners. I took it that the additional remuneration was to an extent necessary to draw an adequate supply.—It has been implemented fully so far as it gives the doctor a sufficient income. We do not think this was designed to effect equitable distribution throughout the country.

1190. I presume it was designed to ensure that every person would have a

doctor within range, and that has been achieved?—Yes.

1191. *Sir Hugh Watson*: These payments are under review at the moment, are they not?—They have recently been, and have been increased.

1192. *Sir David Hughes Parry*: Recommendation No. 6:

"An adjustment in the method of payment in so far as this depends on capitation should be made in the case of practices involving an altogether abnormal number of aged persons and chronic invalids."

Has there been any implementation of that?—None.

1193. None at all?—No.

1194. Can you tell us whether any attempts were made?—*Dr. Davies*: We think it is impossible to do.—*Dr. Wand*: I do not think any attempt has been made. It is a terribly difficult one. You get areas in a big city where you get young people moving out and the old people stay and then you get another type of place where there is a shortage of houses and the young people come and live with the old people. The position is constantly changing. We have taken the swings with the roundabouts within the whole professional field of remuneration.

1195. *Mr. Bonham-Carter*: You get the extreme opposite in the new towns, Dr. Wand?—Yes, the very young. There is no doubt that the Service has been used increasingly since it came in and there is no doubt in my own mind that the younger generation is going to use the Service even more than the older generation. In the younger people you get a greater tendency to go to the doctor for advice, for example, about young children, than with their mothers and grandmothers. I think that is inevitable and it is going on at the present moment.

1196. *Mr. Gunlake*: It has been put to us in evidence that there are areas in the country where there is high morbidity, quite apart from chronic invalids. Do you accept that and think it would have been wise to include that in this recommendation as well as the reference to age?—I would like some more evidence of this increase in morbidity in particular areas before I could answer that.

1197. Perhaps I should say it has been alleged in evidence before us.—That I think strengthens my answer.

1198. *Chairman*: I think it was not an increase, but it was put to us there are the places where there is this great proneness to turn to the doctor, whether genuine or not genuine.—Morbidity means more than a tendency to turn to doctors; it means greater sickness rate, more illness.

1199. *Sir Hugh Watson*: What was in fact said was that the average patient in South Wales has to consult his doctor eight times a year, whereas in the South of England the average patient in fact consults his doctor only three times a year. That is what we understand is meant by high morbidity. And the suggestion made was that there should be some form of loading in these areas for that sort of thing.—I would like some more accurate information. It may be in the area that was chosen, for example in the South of England, that the distance from the doctor was great, that the doctor was engaged in all the difficulties of a rural practice, and that the other was a tighter area.

1200. But in principle, Dr. Wand, would you agree there was something here that ought to be met; that there was a possible way of giving extra remuneration to what you might call overburdened doctors?—I would like to think about this morbidity allegation, because the pool method generally means the average over a doctor's working life. Indeed with a global sum and the pool method that is an essential part of the background. I would want more information, year to year information. I would want to know the precise areas. I would not like to give an answer without all that precise information.

1201. *Chairman*: I do not think we are asking you for that quite, Dr. Wand, but the recommendation of Spens on this matter was that an adjustment in the method of payment, in so far as this depends on capitation, should be made in the case of practices involving altogether abnormal numbers of aged persons and chronic invalids. It may have been so far impossible to devise a system. But do you want this recommendation put into effect? Spens must have considered the matter before recommending it.—I think this is a matter to which a great deal more thought could be given.

1202. You feel Spens rather rushed into this, do you?—No. I think that Spens realised that there was a problem here and made a broad statement.

1203. It was a broad recommendation. —And I think if it was possible to get further information of a precise nature that it would be worth looking into again, but the information must be precise. It must be more or less pinpointed because you can get variations as between practice and practice within the same area, almost the same street.

1204. *Sir Hugh Watson*: May I put this to you, Dr. Wand? The National Health Service has been in operation for ten years and the British Medical Association have not felt that this was a problem so urgent as to make them take it up.—That is so.

1205. *Mrs. Baxter*: Would you agree, Dr. Wand, in a population increasingly ageing, it might be very relevant to any recommendations for the future that this question of the areas where aged persons are to be found should be of particular interest?—If the aged people are gathered together deliberately into a particular place, certainly. But if they are scattered amongst the community then you get a broad principle, as I said, of the average over a doctor's life.

1206. *Chairman*: It does happen sometimes that the ageing people are gathered together in particular places?—Yes.

1207. It is not purely a theoretical doctrine?—No, I agree.

1208. But this is a recommendation of Spens—in your view, one of the less important ones—that has not been carried out? You think perhaps you need a lot more information before deciding on any recommendations as to how it can be carried out?—I would agree that this is a matter which is well worthy of consideration and investigation in the near future in the light of the remarks that have just been made.

1209. But in your memorandum you do say in large black type, that a proper implementation of the Spens Report is fundamental to the Association's case.—Yes.

1210. *Sir David Hughes Parry*: Would it involve anything other than distribution, if I may put it that way? It is a matter of distribution?—Yes.—*Dr. Stevenson*: And loading.

1211. It is not a matter of adding anything to the pool, but a matter of distribution?—*Dr. Wand*: Yes.

1212. Recommendation No. 7:

"On completion of resident hospital appointments a recently qualified practitioner should secure an initial net income of not less than £500 p.a., as an assistant to a doctor in general practice."

That has been implemented, has it?—I think you can say, approximately. In practices which I know the net income is a properly betterment £500 a year.

1213. *Sir Hugh Watson*: You said in practices of which you were aware that obtains, but the recommendation as quoted by Sir David is that on completion of resident hospital appointments a recently qualified practitioner should secure that income. Have any steps in fact been taken to ensure he does secure that?—This is a matter of arrangement between the assistant and the principal.

1214. Was that what Spens contemplated?—This was a recommendation.

1215. But did Spens contemplate that it was to be left between the principal and the assistant?—I think, necessarily so. The words are just set out as an indication of their opinion, their advice.

1216. With respect, this is a recommendation; this is not taken from a paragraph in the Report, but is a formal recommendation that this income should be secured. I think your legal advisers will tell you that secured means something more than being left to the discretion or whim of the practitioner.—*Mr. Cooke*: I think the lawyer's advice would be that if in fact private arrangements between the doctor and assistant are made, there is no need for any other machinery.

1217. We have evidence in point of fact that these payments are sometimes not being made to assistants. But that will be thrown up by the questionnaire.—*Dr. Wand*: Yes. For example, when a man's list goes up above his permitted maximum he has got to do certain things. Either steps have to be taken to reduce it or he has to take an assistant or a partner. If he takes an assistant and has only two or three hundred more than the permitted maximum it is unreasonable to expect him

to take a full-time assistant. He is permitted by the Local Executive Council to take, for example, a part-time assistant at a lower rate of remuneration. I would like to know if some of these lower figures are not in respect of doctors who are in fact doing such part time.

1218. *Chairman*: This recommendation, Dr. Wand, was that a recently qualified practitioner should secure an initial net income that at today's date would be £1,050.—It would be more than that.

1219. Adding the Danckwerts 100 per cent. and the recent 5 per cent.—The recent 5 per cent., yes.

1220. That makes it £1,050?—Yes.

1221. Do I understand that the B.M.A. accept the recommendation that a recently qualified practitioner should secure an initial net income at today's date of not less than £1,050 as an assistant to a doctor in general practice?

—*Dr. Stevenson*: Mr. Chairman, I have always read recommendation (7) of the Spens Report in conjunction with that paragraph on page 9 which deals with the trainee assistant scheme. It goes on to say there that doctors should receive £500 in the first year, and so on, and that this should be a good introduction to general practice. In so far as the £500 refers to that category of practitioner—and Spens of course did envisage that this was a very good way of attracting young men into general practice—implementation has been effected through the trainee assistant scheme, the figures for which are under review from time to time. I am not at all clear that in fact recommendation (7) does apply to assistants not of the trainee kind.

1222. *Sir David Hughes Parry*: It follows then, as a matter of course, that if the trainee assistant received £1,050 the ordinary assistant would get more?—Of course, one would set the pace for the other.—*Dr. Davies*: May I help you, Sir, in referring to the figures extracted from an analysis of British Medical Journal advertisements? In the year 1956-57 the average salary, including car allowance but not subsistence, was £1,055 per annum. The number of advertisements to which that applied was 195.

1223. *Mr. Gunlake*: But that is an average. The Spens recommendation was that this should be a minimum. Have you figures showing that?—No. I cannot give you that, Sir.

1224. *Chairman*: This would seem to suggest that it would be in the power of the B.M.A. to help in seeing that their members do not offer less than these figures, since the B.M.A. accept the basis of Spens. Would that be a fair conclusion or not?—*Dr. Wand*: Well, Sir Harry, as I said earlier on, there are different circumstances in which assistants are taken, and to determine precisely the terms of employment of every assistant in every practice by the setting up of rules in regard to advertisements would be impossible. By and large the advice given by our Bureau is consistent with the statement that I made earlier on—that the majority of full-time assistants in full practice do get the fully betterment £500 a year.

1225. *Mrs. Baxter*: Might I ask whether that is the initial net income?—I have no information about that because once an assistant is in a practice his future arrangements will be between him and his principal; or he may leave because he does not like the arrangements. One does not know what goes on because it is a private arrangement.

1226. The words in the recommendation are "initial net income".—*Dr. Stevenson*: I think the recommendation does not refer to the type of assistant about which Dr. Wand is talking. It refers to the public trainee scheme.

1227. *Chairman*: I think you have said, in reply to Sir David, that the fully qualified doctor, not the trainee assistant, would naturally be paid more than the trainee since the figure for the trainee would set the pace?—Yes.

1228. So we would expect nobody to be getting less than this figure?—Yes.

1229. I did not expect we should be getting so involved in this at this stage, but it does seem to be of some importance because this is a recommendation that the B.M.A. accepts; this is part of the Spens Report that they accept, is it not?—*Dr. Davies*: Yes.

1230. And this is something which they can, through their membership, take steps to see carried out?—*Dr. Wand*: By advice and indication, yes, but not

by a restriction of advertisement. Exhortation is the word I think.

1231. Advice and exhortation have in fact been consistently used throughout the last eight years on this?—Our Medical Practices Advisory Bureau does give advice on this subject and, if you wish, we would bring along the Director of the Advisory Bureau. You could have the precise terms of his advice, which I cannot quote to you off the cuff.

1232. I have here some figures, Dr. Wand, submitted by another body, which cover a slightly different period from the period Dr. Davies mentioned; in fact a shorter one, up to April last year. Those figures analysed 100 vacancies advertised in the B.M.J., and of those, 14 offered less than £1,000, whether initial or not I do not know; they might even not be initial. I wondered whether the B.M.A. felt any responsibility to try and ensure that the initial minimum was observed?—We do not know whether those jobs were filled, or whether they were even filled at that price. In some cases we do get advertisers who just do not know when they put in an advertisement what the current price is, what the current remuneration should be. When they get their replies the person who is applying for the job will put them right. (Laughter.) That is not so facetious as it may sound. It simply means that assistants say: "That is not the right salary to offer me; I am not interested at that price." That is what I mean by putting them right.

1233. *Professor Jewkes*: This surely is a most important point that Dr. Wand has raised, because in fact all these figures that are being quoted are figures of salaries offered. It might conceivably be that these are also figures of salaries rejected?—It could be, yes.

1234. *Chairman*: Dr. Wand, we have some figures following on a questionnaire conducted elsewhere showing a considerable number of assistants receiving less than the minimum figure—we will deal with that later on. But the point here is that the B.M.A. approve of this recommendation, regard it as part of Spens, and are not quite aware of the extent to which it has in fact been carried out?—That is so.

1235. But you think it should be carried out? You attach importance to it?—Yes.

1236. *Professor Jewkes*: In this connection perhaps it would be useful to mention that in the factual memorandum presented by the Ministry of Health, on page 98, there is in fact an analysis of salaries offered to assistants, and this shows in great detail the number of offers at each salary range. It does look there as if in 50 per cent. of the cases the salary offered was less than £1,050. As you say, these may not be salaries accepted, but at first glance one would think this does suggest that less than £1,050 is perhaps sometimes being taken.

Chairman: £1,000 would be the appropriate figure at that time; that was before the 5 per cent.—But there are also other factors. In some cases arrangements are made with an assistant to give him a salary and pay him a proportion, shall we say, of the maternity fee. That was an old custom; I do not say I approve or disapprove of that; but I want to indicate that sometimes the salary is not the total remuneration. In some cases the salary includes a modified sum for subsistence when the assistant lives, shall we say, in a principal's house or a house belonging to a principal. The assessment of the value of the emoluments may be made in a particular way. There are all sorts of factors which have to be gathered together, and that is why I have been reluctant to give you a simple yes or no to one or two of the questions. There are so many imponderables and so many differences as between one assistant in one practice and another assistant in another practice. With the facts before me complete for each one it would be much easier to give a definite answer on each individual case, but you do appreciate the difficulties because of these factors.

1237. Yes, Dr. Wand. We are not at this stage dealing with any suggestion by anybody of exploitation or anything like that.—No, quite.

1238. The question is this. Here is one of the Spens recommendations; this is one which you accept. We do not know the extent to which it has been carried out, although Dr. Stevenson says that, in regard to the part to which he felt the recommendation really related, it has been carried out.—*Dr. Stevenson*: I would say probably not.

1239. *Professor Jewkes*: Has it been carried out in the case of trainees?—

I say probably not.—*Dr. Davies*: Within a small margin. There was a recent increment which was applied following the interim award which brought the total value to £1,000.—*Dr. Stevenson*: I think it is £850 and £150 car allowance, making a total of £1,000 with expenses paid. So I suppose broadly it is getting on towards the 1952 figure but not the 1958 figure.

1240. *Sir David Hughes Parry*: May I for the purposes of the record clear up two things, one with *Dr. Stevenson*? I should have thought, reading this last paragraph on page 9 of the Spens Report on practitioners, that the two opening sentences refer to assistants generally without any question:—

"Altogether apart from the problem with which we are now concerned we had decided to recommend that after the completion of house appointments a doctor who wished to enter general practice should spend one and preferably two years as an assistant, and receive a net salary of not less than £500 per annum."

Then it goes on to deal with one specific type of assistant, namely the trainee. Is not that the construction? Therefore whatever applies to the trainee surely applies to the other as regards salary—£500 as a minimum?—*Dr. Wand*: I would agree with you, *Sir David*.—*Dr. Stevenson*: One sets the pace for the other.

1241. I should have thought that was quite clear in the circumstances. Really the answer to the question is that you accept recommendation (7), but so far you have left it to free competition to try and implement it. There has been no effort on the part of the Government, except in so far as it pays the trainee fee, and nothing done on the part of the B.M.A. Is that right?—*Dr. Wand*: I would not say nothing done on the part of the B.M.A. We have the Medical Practices Advisory Bureau which does give advice. We could on some other occasion, if you would like some further information, bring along the Director of the Bureau who is a doctor—one of our medical secretaries. He will give you the fullest possible information, much fuller than I can possibly give.

Sir David Hughes Parry: We should be grateful to have that.

1242. *Mr. Bonham-Carter*: The fact does remain that it is a matter of private

arrangement and it cannot be enforced by the B.M.A. or any other body in present circumstances?—That is so.

1243. *Sir David Hughes Parry*: I think we should take note, therefore, of the extent to which these seven recommendations have been implemented. I do not think we need go over them again; we have gone through each one of them. Some have been fully implemented, with others every effort has been made to implement them—we do not quite know what the general result of that effort is—and there is one that has so far been found impracticable to implement, is that right?—I think that roughly sums it up.

Chairman: Taking them just generally, those are the only recommendations of Spens, are they not, broadly speaking? Those are the ones shown in the summary. We have gone through them all and I think that is the total.

1244. *Sir David Hughes Parry*: There is one to which I would refer. Would you look at page 8? There is one with which you, *Dr. Wand*, are very familiar:—

"If the recruitment and status of the profession are to be maintained men must be able to feel that more than ordinary ability and effort receive an adequate reward."

That has never been implemented, outside the capitation fee, has it?—No. I would like to refer again to paragraph 14 which starts on that page, and which continues right down to the bottom of page 9, where you see that under certain circumstances 10 per cent. of practitioners were to get an increased sum of money for doing certain things. That was a suggestion. Other suggestions were made later on in regard to a post-graduate course for example. These suggestions were made and a sum of money was suggested as being necessary to carry them out, a sum of money which is referred to as a 6d. in paragraph 19. May I refer to Appendix II to our memorandum—the case we presented to *Mr. Justice Danckwerts*? You will see that when the Ministers came to fix their own figure they were able to use as a starting point certain conclusions reached by Professor Bradford Hill. These conclusions were set out in paragraph 15 (1) and (2) of the case. In (2) you see that if recommendations Nos. (1) and (2) of the Spens Committee had been

applied the sum of money would be increased by £3.1m. As I said earlier on, I have been trying to find out if that included this paragraph 14, and I have not found any evidence of it at all. In the payments which are made to general practitioners this sum for trainee assistants which has replaced the suggestion of Spens has been taken from the pool. That sum of money in my view should have been extra to the pool and applied for the purpose of the early part of paragraph 13, page 8. As it is it has come out of the central pool and unless I can be satisfied that it was not included in the computation of £3.1m.—and I am only saying I have no evidence that it was ever included—I should have thought that this sum would have been made available outside the pool, with the appropriate betterment of course.

1245. I wonder if I can now take you through certain suggestions that were made in the body of the Spens Report and which have not been incorporated in the seven firm recommendations. I am glad to hear you refer to these as hopes and suggestions—or suggestions at any rate.—Some are hopes, some recommendations, some suggestions.

1246. In the body they are hopes and suggestions rather than recommendations.—I would not like to give a dogmatic “yes” on that, but I think in general terms that must be so.

1247. May we take paragraph 6; that is the first one which contains one of these suggestions. The last two sentences:—

“We leave to others the problem of the necessary adjustment to present conditions . . .”

That presumably is referring forward to Danckwerts, is that right?

Professor Jewkes: An extraordinary example of prescience if it was!—Shall we say Danckwerts and all that should have followed from Danckwerts.

1248. *Sir David Hughes Parry:*

“ . . . but we would observe in this connection that such adjustment should have direct regard not only to estimates of the change in the value of money but to the increases which have in fact taken place since 1939 in incomes in other professions.”

That is the Danckwerts suggestion, is it not, that you should compare the general

practitioner remuneration with the income in other professions?—I do not think it is as simple as that, Sir David. I have read this through many times, and I am quite satisfied that what this means is this: that you have obviously got to have regard to the change in the value of money; that is what they say. But they say, having had regard to the change in the value of money, in order to maintain your status you have got to be sure that the other professions do not run away from you. So that, having got your change in the value of money allowed for, you have got to make sure that somebody has not got up above you. Therefore that is the second point that you have to consider, not a parallel point. You take your value of money; if the other professions have not got ahead of you in value of money that is that, that is the end of the computation. But if they have got ahead of you in the value of money you have then got to make an allowance on top of that first computation in order that you may compete on equal terms at least with other professions for the men of the best ability. I think that is what that means; that is my view.

1249. *Chairman:* I take it, Dr. Wand, that at the present time you are rather inclined to think that other professions have gone ahead of you?—I think so if you include professions in the widest sense.

1250. That is another matter; but I take it you think that at the moment they have got ahead of you. That is your point, is it not?—I think I would rather Professor Allen answered this because it is a matter of economics on which I must be advised.

1251. I am pursuing the broad question.—May I say in answer to that just that I do not know how far that second point applies at this moment.

1252. All right. If you considered that you had got well ahead of other professions by any chance, which I believe you do not at the moment consider, would you hold that the first part only of this statement applied?—I would.

1253. You would consider that this ensured that you had the choice of either of two methods to . . . —No.

1254. I thought that was what you said?—No, I did not say two methods.

I said we had got to be level pegging with the value of money with the remainder of the population. I am not an economist, I cannot speak in precise terms on that, but in general terms value of money is the rest of the whole population. On top of that, competition with the other professions for the best available ability, for the best available men and women for medicine.

1255. *Professor Jewkes*: Could I put it this way, Mr. Chairman, to see if Dr. Wand agrees with this? Are you really saying that the earnings of the general practitioner should increase either correspondingly to any decrease in the value of money, or correspondingly to the increase in other professions, whichever is the higher?—I think it means that.

Chairman: It is useful to have that statement in such a plain form.

(The proceedings were adjourned for lunch)

On Resumption

Chairman: Dr. Wand, Sir David Hughes Parry was just going to turn to paragraph 8 on page 5 of the Spens Report.

1256. *Sir David Hughes Parry*: If you remember, we are dealing with the suggestions or hopes expressed in the main body of the Spens Report. There is this sentence on page 5:—

"We consider that unless conditions are substantially improved in both these respects, and on the basis of a pre-war value of money, the social and economic status and the recruitment of general medical practice could not, in the long run, be maintained."

Then later in the same paragraph about six or seven lines from the end:—

"We, and not least our lay members, consider that it would be disastrous to the profession and to the public if general practice were recruited only from the less able young doctors. We consider, however, that unless the financial expectations in general practice are substantially improved, the great majority of the able men will seek to become specialists, in view of the fact that as specialists they have an equal outlet for their interests in medicine . . ."

and so on. What the Commission would like to hear is your opinion generally as

to whether these improvements and their distribution have resulted in the maintaining of the social and economic status of general medical practice, whether they have caused recruitment to deteriorate, if I may use that expression, and whether general practice has held its own with consultant practice. Those are the three main hopes that the Committee expressed in this paragraph. Would you deal with each one of those?—*Dr. Wand*: I think I can say that the change brought about by the award of Mr. Justice Danckwerts has by and large resulted in these factors being dealt with adequately.

1257. All three?—I should say so, by and large.

1258. We shall in due course deal with the Spens Report on Consultants. We will take the opportunity then of dealing with the award that was made to consultants after the Danckwerts Report and compare the two. I think we had better leave that until we have dealt with consultants.—*Sir David*, may I make something quite clear in that reply? I am taking your question in the context of the situation as it existed at that time.

1259. At what time?—After the Danckwerts award. Similarly some of your questions this morning on the recommendations of Spens. So far as the money factor is concerned, I am talking entirely in terms of money as at that time.

1260. I appreciate that.—Changes may have taken place since because the decrease in the value of money has not been properly dealt with, but that I think is the answer to your question.

1261. As regards recruitment, I am not quite certain from paragraph 110 of your memorandum whether there is an implication, or simply an expression of fear, that the standard of recruitment may be going down? If you would make that quite clear?—Which are you particularly referring to?

1262. I am referring to the last part:—

"If the remuneration of the profession is progressively and relatively reduced there can be little incentive, other than that of vocation, for an entry into medicine. In other parts of the world where the salaries of the medical profession have been 'pegged' during an inflationary period there has

been a marked fall in quality of the entry of medical students."

There is no implication there, is there, that the quality of those entering general practice is lower than it was?—That is not the implication at the moment, but there is another implication that perhaps Mr. Holmes Sellors will deal with.—*Mr. Holmes Sellors*: The other implication is that in certain countries I have visited, particularly countries in South America, where they have a state service and where there has been a fairly heavy inflationary period with pegged medical salaries, there has been a considerable movement from the medical profession into other callings. I knew three or four doctors who were taking up commercial travelling because the medical profession did not give them sufficient financial incentive to continue. That sort of thing had affected their student intake very considerably and it was becoming a major problem in their health service at that time.

1263. It is really then an expression of fear, in case?—*Dr. Wand*: Yes, that puts it very well.

Sir David Hughes Parry: I was not quite certain when I read that paragraph.

1264. *Chairman*: In these countries to which you refer are general practitioners in a salaried service?—*Mr. Holmes Sellors*: They are in a salaried service very largely, with a very limited private outlet.

1265. It is not a capitation fee, it is basically salary?—Yes.

1266. And in those countries inflation has run away?—The inflation has been so large that men have actually moved to other work. Two men I met in actual fact were giving up their practices and had jobs as commercial travellers.

1267. Has their remuneration been adjusted at the same rate as the civil service, for instance, or government employees?—I think they were kept about the same as far as I knew.

1268. *Sir David Hughes Parry*: I take it that you have studied the Willink Report on the intake of medical students? Do you wish to make any observation on that? Would you accept it generally, because the question of recruitment is important?—*Dr. Wand*: There is no Association policy on the Willink Report because it has not yet

been studied adequately for that purpose. But we have with us one of the members of the Willink Committee.—*Dr. Davies*: I was a member of the Willink Committee, Sir.

1269. You agree with it?—I signed the document.

1270. The opinion there is that recruitment so far has been adequate.—Adequate to the present time.

1271. And the number of students to be accepted might be diminished?—That is a long-term view, Sir. It is envisaged that, providing present-day conditions remain static, a state of satisfying the demand should be reached about the year 1965 as regards requirements for the output of medical students as qualified medical men. The demand and the supply should meet in the year 1965.

1272. So the general conclusion would be, would it not, that the trials and tribulations of the profession as regards remuneration have not affected recruitment in quality or in quantity. Is that right?—*Dr. Wand*: That cannot be taken quite like that. A boy makes up his mind, or his parent makes up his mind, that he is going to go in for medicine when the boy is 15 or 16 years of age. And the boy is not qualified until he is 24 or 25. So the decision has got to be made considerably anterior to the point at which you will get the information. The Danckwerts award was not made until 1952, and the impact of the Danckwerts award on the number of students who were going to find their way ultimately into the universities would not be known until considerably after that time. Even now it would only just be beginning to show itself. When I say that the boy makes up his mind to go in for medicine at the age of 16 perhaps I am even then putting the age too high. I think most boys who decide on a career in medicine or in science make up their minds rather before that time. So you will not yet get the impact of the advantages of the Danckwerts award, or the disadvantages of the inflationary slide to which the profession has been subjected adequately shown in figures. But even so it is an extraordinary thing that the figures that are being produced—for example those in the report to this Commission of the Royal College of Physicians of Edinburgh—show that the number of applications is going down;

and some figures that I have before me show that most of the people seem to be getting in. When you take into consideration the number of multiple applications that are being made the figures are not very illuminating in the sense of being completely accurate, but they do seem to indicate something of that nature.

1273. *Chairman*: These people you are talking about, what age are they?—I am speaking now of the entry to the universities.

1274. That is to say people from the period before the war when the birth rate was rather low?—No, the figures I have got are the relative figures for acceptances and non-acceptances in the various universities at this present moment, or rather the date at which they were given.

1275. People born in 1939 or thereabouts?—Yes, I suppose so.

1276. *Sir Hugh Watson*: Dr. Wand, may I ask you a question about the Edinburgh figures to which you refer? I have them in front of me, and it appears that in the only pre-war year for which a figure was given the number of those who applied for admittance to Edinburgh University was 521, of which 212 were accepted?—Yes.

1277. If you go on to the period when you work off what you might call the backlog that rose up during the war, you find in the five years succeeding that the average appeared to be about 800 applying, and the average who were accepted was about 178. The number who were accepted was in the control of the University, was it not?—Yes.

1278. There does not appear to be much diminution in the demand there, does there Dr. Wand?—No, I was saying I think from what one's knowledge is that the number of multiple applications has increased enormously; nobody seems to know quite how many multiple applications are made to universities. The figure of 2.1 for men and 2.5 for women has been used, but I do not think that is accurate because that excludes the individual colleges at Oxford and Cambridge. We do not know how many men applied, for example, to go to half a dozen colleges. I know when my son went to Cambridge he naturally applied for three and so he would have appeared as three applications. He also applied to

a provincial university, so he had four applications, all of which were actually accepted.

1279. *Sir David Hughes Parry*: Would you agree, Dr. Wand, that the financial incentive to enter the medical profession was not quite so powerful before Danckwerts as after Danckwerts?—I would.

1280. You say there is a lag of three or four years perhaps between the time students enter the university and the time they decide to go in for medicine?—No, I said there was a longer lag. I said the boy may determine or it may be determined for him, whether he is going into medicine or not at the age of 15 or 16. I did use the figure 16. I said I thought perhaps even that was rather high because boys very often make up their minds before that time. By the time these boys have qualified when they are 24 years of age there has been a gap of eight or maybe nine years.

1281. As much as that?—A boy does not go into medical school until on the average—I think we have some figures somewhere—17½ years of age, and the average age of qualification is about 24½, so that is seven years. From say 15½ to 24½ is nine years. It is only just over 5 years since Mr. Justice Danckwerts actually reported, and it was some little time after before the impact was known.

1282. We are really, are we not, talking about the entry into the university rather than the passing out from the university. We have figures to indicate what the entry is at the present moment in 1957. Allowing three years' lag, or four years' lag, from the decision to enter for medicine, those that are entering or have recently been entering universities have been entering under the economic incentive of Danckwerts, is that right?—We are on very dangerous ground here because there are so many imponderables—the war, the aftermath of the war, the change in population, the movements of families, people coming back from the war, senior men coming back from the war with their families, all sorts of factors enter here. I am trying to answer your question, Sir, but the question which you asked me, if I remember rightly, going back a bit now, is a question relating to the financial attractions of medicine.

1283. And their effect on recruitment. —And their effect on recruitment. I am only saying that it is not yet time to measure the improved attractions produced by the Danckwerts award in terms of entry into the medical schools. Other points, for example, are the fact that the Government has now attracted a larger number of people by its increased grants to universities in general terms. In that way it has increased the field from which people can go.

1284. What I was suggesting to you was that even before the Danckwerts award there were no signs—there are no signs now—of under-recruitment either in quality or in quantity for entry to qualify as a doctor?—In quantity I cannot say, because we do not know how many multiple applications were made. We know that the medical schools have had in the main a larger number of applications than they had places. We do not know, because of the multiple applications, by how much that exceeded the number of places in previous years and whether that excess has gone up or down. We do not know that, so on the first question I do not feel I am able to answer you accurately. The second question again is difficult to answer. I personally can only assess the quality of those with whom I come into personal contact, my partners, my assistants, the doctors whom one meets in the evenings. The teaching hospital staff are much better able to do that, and I feel that it would be improper for me to make a statement of that kind.

1285. We will take an opportunity when the university representatives are before us to question them upon this matter, because we would like to be assured on it, naturally.—I think they would be the best people. I do not think they would be able to make a complete and absolutely accurate assessment, but I think they are best able to make some kind of assessment.

1286. *Professor Jewkes*: If I might just ask a supplementary question there. Although it is very difficult to state whether present earning levels of doctors are tending to reduce the supply, is there any evidence that there is shortage of doctors of any particular type? You will recall that at some stage in your evidence you mentioned the problem of registrars. We want to deal with hospital staff I suppose generally together, but

you do mention one shortage there. Is this significant in any way? Does this arise from the fact that earnings of doctors in your opinion have not risen as they should have done?—Yes, there is no doubt about it. There are three particular fields here. The first is the junior hospital staff where I understand there is still a considerable shortage. The second is the armed forces, and the third is the public health field. You will have evidence from the public health field in due course I expect, and the armed forces; I have no doubt you have the figures.—*Dr. Davies*: There is also a shortage in the prison medical service, which is a small matter.

1287. *Sir David Hughes Parry*: The only other matter that I have which we might as well dispose of now, is the ability of general practice to hold its own with consultant attractions. Do you think that on the whole the balance is reasonably held as regards remuneration of the two branches of the profession?—*Dr. Wand*: I think you have got to look at this from the widest possible standpoint. You have to look at it from the point of view of remuneration and risks over the whole of a man's professional career. Some of the people who want to become consultants will fall by the way and will lose thereby financially; they will lose money on the road back—finding their way back to another road. The general practitioner is in the main able to earn a sum of money on which he can live at an earlier age than the consultant. He is also able to go on for a greater number of years, he can go on until he is 70 if he likes. Whether you think that is a desirable argument or not I do not know; I should not have thought it was a very good one, but still there is the fact. We know that the consultant can attain very much higher earnings. Nevertheless, we have been satisfied that in general practice the proper way of dealing with this problem is to implement Spens by the use of the global sum method, and arrange a distribution. Indeed in the Working Party we did arrange a re-distribution which gave practically nothing to the men at the top in order to assist those in the middle groups. This sort of re-distribution was indicated in the Working Party's terms of reference. We are not going to complain about that; we have these differentials. I would draw your attention once more to a statement I made this morning, and

that is that I have no evidence that paragraph 14 of Spens has been implemented. I think in the context of your question, something on the lines of paragraph 14 outwith the global sum might deal with the exceptional case which arises where the gap is a little too wide to be spanned by the bridge of ordinary distribution machinery.

1288. We have that very much in mind since this morning.—You will realise that what I am saying is that the big-list practitioner, as he is called in general practice, is earning below the maximum figure set out in Spens. The maximum figure set out in Spens is £2,500 plus, which with betterment of even 100 per cent. comes to over £5,000. This is a much bigger sum than any general practitioner can earn. There may be one or two very rare exceptions over a short period of time as I would explain to you if you asked me. But I think that this sort of gap ought to be bridged to some extent; and I think paragraph 14 gives the clue—outwith the global sum. Really what paragraph 14 was trying to find was a merit award for general practitioners.

1289. Something additional?—Yes.

1290. *Professor Jewkes*: Would you like to comment on that? That was a question I was going to ask. What about merit awards for general practitioners?—If a scheme could be found that could use these paragraph 14 moneys fairly and properly I think my colleagues would welcome it, but many committees have looked at it. Lord Cohen, or Sir Henry Cohen as he then was, looked at this problem, but could not find an answer. We have not found an answer. It is difficult. How are you going to assess a man's ability? By age? By experience? Quite probably that may be quite the proper way, but there are also a number of other factors. Are you going to decide by the man's degrees? A man can get an M.D. at a university by writing a thesis on something which is of absolutely no value at all to clinical medicine.

1291. *Chairman*: How is ability assessed at the moment?—The ability to attract patients, that patients will put their trust in you, and continue to put their trust in you.

1292. So that the more patients you have on your books the more able you are?—I think it can reasonably be said

that on the whole that is so. When your list reaches the maximum—which was reduced as you know after the Working Party's report—then according to Spens it should be possible for you, by employing an assistant, to spread the value of that ability over a still larger number of people. That is indicated in the Spens Report.—*Dr. Davies*: May I add something here, Sir? In view of some evidence you have received and to which some publicity has been given, I hope the Royal Commission do not regard general practitioners as part of an inferior race. They are by no means failed specialists; the majority of general practitioners are family doctors by vocation.

1293. We gather, *Dr. Davies*, that the profession, and also the lay members of the Spens Committee, attached a great deal of importance to that point at that time. That is also the view of the B.M.A. as a whole?—That is so, and in fact the White Paper at the inauguration of the service said that the family doctor service should be the foundation of the whole Health Service.

Sir David Hughes Parry: The whole object of the questioning has been to draw this out and to get your views on it. That is why I am pressing the matter.

1294. *Mr. Gunlake*: On the question of the size of list, some of our witnesses have urged that the present maximum should again be reduced. What would be the attitude of your Association on that?—*Dr. Wand*: The lists were reduced by the Working Party in 1952 or 1953. The lists were reduced in effect when the Health Service came into operation in 1948. What is the right list? I think we can say from experience that a good experienced doctor who is prepared to work hard does not find the present sized list too great a burden. When I say work hard I mean work hard as a doctor knows hard work. I do not think it can be regarded as too great a burden. But I would say this, that most of us feel that the work per patient has increased, is increasing, and is likely to go on increasing. And I think if that increase does go on to some greater extent, the situation will have to be looked at again. Then I think there will come this question of re-distribution in respect of such global sum as may be determined,

just as happened after the Danckwerts award.

1295. *Chairman*: Does that mean, Dr. Wand, that you would not then agree with the Willink Committee's conclusion that there are enough doctors in prospect?—The Willink Committee's Report was an excellent report but—well, it was really asked to look into a crystal ball.

1296. Do you agree with its conclusions?—I said earlier on that we had not yet discussed them and analysed them sufficiently to be able to say whether we agreed or disagreed. But they looked into a crystal ball, as I say, and throughout the document you will see phrases which indicate that it may be this way, or it may be that way, it may be like this, it may be like that. There was a good deal of uncertainty, and I think in the face of these uncertainties they produced a report which was rather striking in the material it contained and for the results that they achieved. But so far as their findings are concerned there has been no firm determination made yet by the Association. But it may be that there would be need for more general practitioners if the work continues to increase.

1297. Meanwhile you say items of service per patient are tending to increase?—I have no precise figures. Taking the prescription figures and allowing for all the variations that have taken place—for example, the fact that the prescription charge has sometimes deterred people from taking prescriptions to the chemists, the fact that we have been encouraged since the recent increase to give larger quantities and so on—the prescription figures do indeed indicate that the items of service have gone up. But what has gone up much more than that is the time taken per patient. There is no doubt about that, and that is a thing that is continuing to increase. The amount of nervous ailments, what is known as psychosis, has increased a great deal with the stresses of modern life. A lot of these people who come in with physical symptoms complain of something which is attached to an organ of the body. It is a much more difficult and time-consuming job to find nothing organic than to find something organic, and we are getting that constantly. And of course we are getting patients realising that we are people to whom

they can come and tell their troubles. We would wish them to do this because if we know their troubles we are able to deal with them better, we are able to treat them better, to guide them and help them. All those are time-consuming things, they are part of a doctor's life. And if this grows, as I said it would appear to be growing, then the number of doctors that will be needed may be greater. Another point of course is that as improvements take place in medicine, as we get our antibiotics and so on, we cure our people more effectively perhaps in some cases, more easily in other cases. But the result of these new measures very often is that a man who would previously have been untreatable or who might have died becomes a case who is going to attend the doctor for the rest of his natural life, which may be almost as long as that of anybody else. The diabetic is not a recent example but is the sort of thing that might put it in your minds. So that if we get in the future, for example, a cure for cancer, it may be that that cure for cancer will be something that will require not only the constant attention of the doctor for the rest of that person's life; it may also mean constant tests at laboratories, X-rays, pathological tests and what have you for the rest of his natural life. Those are things we do not know about; but we do know that the modern improvements in medicine have resulted in more work for the doctor in very many fields indeed, because of the tests, the watchfulness we have to have, and the care. So many of these wonder drugs, and believe me they are wonderful, have meant a great deal more careful observation of a patient because they have so many side effects and dangers. I am sorry to have been so long on this point.

1298. *Mr. Gunlake*: These matters raise certain difficulties in my mind, Dr. Wand. You said earlier it was your desire that the abler general practitioner should be remunerated in some additional way, if a way could be found, but that the only way that has been found, despite a great deal of effort, is to rely on the law of supply and demand in the sense that the abler practitioner will attract a larger number of patients. Having regard to those witnesses who have contended before us that the maximum size of list as it at present stands should be still further reduced, all you

have been saying in the last ten minutes suggests to my mind that circumstances are going to remove, or at any rate diminish, this method of rewarding the abler general practitioner.—I cannot see that; I cannot see that at all.

1299. *Chairman*: Do you consider then, Dr. Wand, with all these things, that the abler general practitioner can still deal with as many as he did before? —I said, and I stand by this statement, that at the present moment the able general practitioner can deal with a list of the present maximum, but I am indicating that the trend of affairs in medicine may lead to the necessity at some unknown future date of revising this situation. I am sorry I got led away, Sir Harry, but that was the trend of what I was saying.—*Dr. Davies*: Sir, the debate has moved rather fast in the last quarter of an hour, and one or two threads are still lying loose. There have been references again to the Willink Committee, Sir. May I remind the Royal Commission that in my first observations I did say the Willink Committee reported under conditions which would be assumed to be static. By that we mean that there would be no state of war, for example, no major government legislation altering the structure of the health service, and no major scientific discovery or scientific methods which would alter the health service procedure as it was at the time the Committee reported. Now, having said that, the Willink Committee also had some observations on the size of lists. You have the document. It is reported in paragraph 37 at the top of page 12. You also have, because there has been reference to it today, the Central Health Services Council Report on General Practice, commonly known as the Cohen Committee Report. They also make observations in paragraph 42 on page 14. I should like to amplify what Dr. Wand said about the ability of doctors. Ability does vary and, in addition to ability, there are such things as method and organisation, and an able and efficient doctor with good organisation can deal with much more work and more patients than a doctor who does not have this inborn natural ability or the power of organisation. However, doctors do work very hard according to their ability, and we have no evidence whatever to show that doctors with large lists are giving an inferior service.

1300. *Professor Jewkes*: Of course I can understand everything that Dr. Davies has been saying, but in one way or another we have got to make up our minds what is happening both on the supply side and on the demand side. On the supply side I think Dr. Wand has explained that it is very difficult indeed to see whether the failure of doctors' earnings to rise since 1950 has had any real effect on supply. But on the demand side we have the Willink Report—and Dr. Davies was a member of that Committee. The Willink Report contains the best information that is available for us on this subject, and one of its conclusions—the second conclusion on the last page is:—

"Up to 1961 output from the medical schools is already substantially determined by the number of students now at various stages in training. After that year however a reduced output will suffice."

The Willink Report is suggesting—and in fact present evidence seems to confirm this—that after 1961 a reduced output will be sufficient, although later on again in 1975 it will have to go up. Is it right for us to deduce from that that, looking over the next 10 or 15 years, there is going to be no increase in the demand for doctors? Because this would be a surprising conclusion to arrive at in view of what Dr. Wand has already explained to us about the responsibilities of doctors in general practice?—*Dr. Wand*: I said if they go on.—*Dr. Davies*: Dr. Wand was referring to a tendency, I think that was the word he used at the beginning of his remarks. I would agree there is a tendency, and the evidence on which that opinion is based is the lengthening of surgery hours.

1301. You meet the increased demand for doctors' services by increasing surgery hours?—Work of a time-consuming nature, yes. It is not more than a tendency; it has not affected my competence to the best of my ability, but the tendency is there.—*Dr. Wand*: I wonder if Professor Jewkes would look at page 32 of the Willink Report? The number of doctors it is indicated will be needed for export is reduced over the next sixteen years, and of course that to a small extent does indicate some change that is going to take place, or is expected to take place.—*Mr. Holmes Sellers*: I would like if I may just to add a word

on the hospital side of the Willink Report. I think that there may well be an increased demand in the hospital services for personnel, with the rapidly changing and developing structure of medicine and surgery, and the need for more and more detailed investigations. When we were preparing evidence for the Willink Committee we had very definite evidence before us that there would be an increasing expansion, certainly in some branches, even though it was realised that others might be diminishing in their requirements as time went on. But I feel that the hospital service as a whole will be undergoing an expansion in numbers in the coming years rather than a reduction.

1302. I am just anxious to know what is the best bet about the future. Nobody knows. The Willink Committee is rather suggesting there will not be an increased demand. You are rather suggesting there may be an increased demand. Is that a fair way of putting it?—*Dr. Davies*: I think that is a fair way of putting it.

1303. *Chairman*: On the point Sir David was raising earlier about the balance between the two sides of the profession, bearing in mind Mr. Holmes Sellers' point that the increasing complexity in some branches means that there may be a bigger expansion in parts of the hospital service, you still feel that the balance is such that people can go into either branch as things now are; that the balance between the two sides is about right at the present?—*Dr. Wand*: I think if Paragraph No. 14 of Spens had been properly implemented I could give you an unqualified "yes." I think I can give you a less dogmatic "yes." Nevertheless a "yes" within the general field of the Spens determinations if properly implemented, with betterment and so on brought right up to date.

1304. I am not talking about distribution between doctors and anybody outside, but as between the two main branches of the service. Do you think that the balance of numbers is about right?—*Mr. Holmes Sellers*: I would suggest at the present time the balance is about right. We know and will probably be discussing the deficiencies in various parts where there may be a tendency to pile up in some areas, but it does not seem to me from the hospital angle to be a major problem at the

present time. There is the major problem of people who cannot get appointments, such as senior registrars, but I imagine that will be a question you will be discussing at some later time.

1305. *Professor Jewkes*: Nevertheless I gather from what Dr. Wand says that if some methods could be devised for making payable some rather higher incomes at the top for general practitioners it would be a useful device?—*Dr. Wand*: I think so and I think, as I say, Paragraph No. 14 of Spens allows for it outside the global sum, which would be a great advantage.

1306. *Professor Jewkes*: Have you any further ideas as to how that can be done? We have talked about merit awards for general practitioners; we have talked about loading for age. What other ideas can be put forward to implement this suggestion?

Chairman: It would be a departure from the capitation system?—No, it would be an additional thing, I think it would be a loading on top of the capitation fee.

1307. *Sir David Hughes Parry*: The capitation fee would be the basis and then there would be an addition?

Professor Jewkes: A bit for experience or age?—Age, experience, special qualifications, special post-graduate training. It is very difficult indeed. I need not explain that you have had brought to your notice some anxieties in the same field amongst consultants. So I hesitate to tread in this field without a good deal more information.

1308. *Sir David Hughes Parry*: Any assistance that you could give would be appreciated.—Thank you very much. We will have another look at it.

Chairman: This really is obviously a very important point. To make the remuneration of general practitioners such that it does give some incentive to efficiency.

1309. *Sir Hugh Watson*: I was a little puzzled when the Chairman asked you the question, why you turned to Mr. Holmes Sellers—I was thinking in terms more of the junior hospital staff than the consultant. Really there are three groups. There is the junior hospital staff; there is the general practitioner; and there is the consultant staff. There are three groups and each group is necessary to the

proper carrying out of the Health Service, and each group has its attractions and its detractions. I was trying to marry the three. I was drawing in Mr. Holmes Sellers because he was concerned with two of these groups. I was thinking in terms of the junior hospital staff.—*Mr. Holmes Sellers*: I could put it briefly. Everyone, whether they go into the hospital service permanently or into general practice, must come through the junior hospital course in the first instance; They must take a qualification through the hospital post-graduate scheme and they must perform house jobs. Therefore we have a common interest in the particular point.—*Dr. Wand*: We will have another look at this. We have looked at it before and never been satisfied about how it could be done. I once drew up a plan which was so involved that even I could not understand it—it would have meant a lot of calculations. I have never yet seen any positive workable suggestion put up which would have commended itself to the bulk of general practitioners. However, I thank you for your suggestion that we should look at it again.

1310. *Sir David Hughes Parry*: We certainly want a practical proposition which can be implemented. Not like No. 6 of the Spens recommendations which we have all found difficult.—*Dr. Davies*: We will look at it.

1311. Thank you. I wonder whether we can go back to paragraph 6 of Spens. There is a statement there which I repeat:

"We leave to others the problem of the necessary adjustment to present conditions."

That refers very largely to the global sum and the betterment, does it not?—*Dr. Wand*: Yes.

1312. I am drawing your attention to the fact that the two things were complicated in the recommendations; a global sum, an adjustment thereto in the future, and the distribution of that fund by members of the profession. That is right, is it not?—I think those are the three features; getting the whole sum together, distributing it properly and adjusting it to the changes that were indicated for the future.

1313. That is right, thank you very much. Those were the three things. Now I would like to spend a little time on the methods of distribution, leaving

aside for the time being the global sum and the adjustments to it because that would involve your claim. Can you assist us as regards the methods of distribution?—*Dr. Davies*: May I give you a picture of the general situation?

1314. Indeed, it would help me.—There is a population in Great Britain of approximately 50 million people and they are not fixed in position. It is almost like an anthill—people are moving about all the time from place to place. In addition, there is somewhere between half a million and three quarters of a million people who visit these shores every year. There are sailors whose occupations take them in and out of the country. There are members of the Armed Forces who are doing their National Service either at home or abroad for about two years of their lives. There are practitioners who are in industrial areas, urban areas; there are others who are in rural areas. There are other practitioners in specially difficult positions, such as those to whom we referred this morning, in the Highlands and Islands, and so on. There are the normal holiday movements of the population—people going to the Isle of Wight or Torquay or Blackpool or Southport and being taken ill there. There are school-children going to school camps. There are people going to advertised camps—I do not know whether I am permitted here to use the word "Butlin's" but that does convey something to most people, the Butlin camp type of holiday.

The only way in which you can supply a medical service to satisfy all these migrations and variations of practice, bearing in mind that every general practitioner has an overall obligation to the whole population—not merely to those on his own list but to the whole population—is by having an elastic distribution scheme. In order to devise a distribution scheme you must have a global sum in which you can operate. Therefore, providing the sum is adequate to supply all these needs then the matters of distribution are matters with which we have always dealt and still do by the process of direct negotiation between the Ministry and the General Medical Services Committee. I do not know whether I have gone far enough for you at the present time?

1315. You think that the question of distribution is properly dealt with in

those negotiations? We are considering now the machinery.—That is our experience, bearing in mind that we have direct access to the Ministry. If there is any evidence at any time of a deterioration of the affairs of a particular section we can, by negotiation with the Ministry, obtain an improvement. That is being done all the time. We have applied that in the last few weeks in the matter of the Shipping Federation, the amount that we pay to certain doctors for attending sailors in port. We have quite recently altered the amount of hardship payments to certain elderly doctors and the initial practice allowance to doctors just starting. These variations are going on all the time by direct negotiation and agreement between the Ministry and ourselves.

1316. *Chairman*: Are these variations done always with Spens in view—to try and put into effect the recommendations of Spens?—Spens is constantly in our minds.

1317. They are done deliberately with that end in view?—Not deliberately, but the picture is always there.

1318. Yes. We felt earlier this morning that none of us knew really to what extent Spens had been implemented by these different methods of distribution.—If you remember, Sir, I did qualify a remark I made this morning. I think you said first of all you did not understand it but the remark I made as regards our action on Spens was 'as far as it is possible to implement it in relation to the distribution.' And I referred to two phases. First of all, when we entered the Service, when certain things were laid down by the then Government, the setting up of the Medical Practices Committee about distribution, the limitation of lists to a certain number and other matters. Then the second phase when the Working Party was set up after Danckwerts and certain other conditions were laid down. As far as it is possible to reconcile Spens with those methods of distribution we try to do so.

1319. And the extent to which you have succeeded so far we shall know better when we have some figures? But so far we do not know?—Yes.

1320. *Professor Jewkes*: Could I just at this point ask for an amplification of some defects which you yourself have suggested are to be found in this method

of employing the central pool. I understand that there are two major items—capitation fees and the payment for other forms of service, maternity service and the like?—Yes, capitation fee and loading.

1321. Yes, they come together, and then there are the other forms of income. As you pointed out in your document, paragraph 185, if for any reason the payment for the other items to general practitioners increases, this has the effect of reducing the capitation fees for all the other doctors in the community. That is true, is it?—Yes.

1322. Is that not a rather serious defect in the scheme? For example, you say "Well, we have got to deal with sailors who come into the country". Suppose there is a sudden increase in the number of sailors and they have got to be dealt with somewhere. Those doctors who treat them will of course get increased payment but the net effect will be a decrease, a small decrease of course, in the capitation fee for every other general practitioner in the country. Is not that a curious and irrational consequence of any system of payment? As a result of extra effort everybody else has to suffer in your own profession?—*Dr. Wand*: Those are the swings and roundabouts which go on for the whole of the practitioner's life. We have accepted the principles enunciated by Spens which have led to the production of a sum of money which is called the global sum and which represents Spens brought up to 1951. We realise that within that field there may be certain minor inconsistencies. But taken over the whole of the doctor's life we feel that these will be to some considerable extent ironed out. These inconsistencies are as nothing so long as we have the Spens global sum with proper betterment so that we can, with our particular knowledge of the situation in these various places, deal with the Government with its own particular knowledge, so as to get the best possible distribution from time to time. That is our contention in the matter, that with all the faults that may lie in this global sum method they are far more than outweighed by the advantages of being able to work out something with which the profession is satisfied. And satisfied for one main reason, that when they came into the service the Government said "We agree with Spens" and

the profession said—and it has honoured its word—"Right, if you agree with Spens we come into the Service."

1323. *Chairman:* Dr. Wand, I am just trying to see which particular part of Spens you are referring to.—In general terms, Sir.

1324. I am trying to see with which particular part that has to be reconciled.—It is in general terms. The general terms are worked out in Spens. It was agreed with the Government that a certain sum of money was necessary to provide for the recommendations of Spens.

1325. Which paragraph is that?—That is a statement made in Appendix 2, paragraphs 15 and 16—the statement of case for the General Medical Services Committee—when we agreed that a certain number of practitioners represented so much money at Spens 1939 values.

1326. No, I was wanting to see it in Spens.—Spens was accepted and this was the calculation that was made by agreement to show the implementation of Spens in terms of money.

1327. Yes. I still cannot quite find where it is that Spens had anything interpretable to the effect that when there were more sailors coming into the country, other general practitioners would get less, because there was that much taken out of the pool.—Spens did not say that. Spens said having regard to what conditions were when Bradford Hill made his analysis, doctors were getting so much money here, there and everywhere. But each doctor's money was made up by a number of items; in the case of this doctor it was perhaps more confinements and in the case of that doctor more sailors who were coming into the country. That produced a range of incomes. Now, even within the range of incomes indicated by Spens you cannot pick out any age group and say that doctors between age 40 and age 45 who in terms of Spens were going to earn £1,000 would have 500 sailors on their lists, or that doctors between the ages of 50 and 60 who were to earn £1,400 were to have 25 confinements in a year. There was nothing of that at all. It was recognised that there was a coming and going as between the years of a doctor's life, a coming and going as between areas of practice, a coming and going as between the abilities of a doctor,

which, by and large, produced the spread of incomes of the kind set out. But before you can get this spread of incomes, even from these various sources, you have got to have a big enough cake to cut up amongst those doctors. Spens produced something which enabled us to determine with the Ministry the size of that cake and how much each doctor on the average should have. Then, just as in the days before Spens reported, you have the various factors coming in. You have the same factors coming in now as then. Indeed, the man who was at a port and had sailors in 1939 is at the port today and has sailors, or his successor has. So the various other factors of Spens will fall in once you have a cake of the right size and divide it by some means of distribution, geographical or otherwise.

1328. *Professor Jewkes:* Dr. Wand, I can see the importance you attach to the central pool because as long as the central pool exists you have a convenient way of trying to make sure that the Government honours what you regard as the Spens recommendations.—Yes.

1329. But what would be the objection to a scheme which would seem to get rid of this difficulty that if one group of general practitioners works a bit harder the capitation fees of other doctors are reduced? Suppose you had a scheme by which there was a separate set of negotiations about capitation fees and loadings apart from negotiations about payments to be made for other items—maternity services and so on—so that you worked under a system in which if the payment for maternity services went up then capitation fees did not go down. That is what I am looking for and it is on that I want your opinion.—If we had that we would have the best of both worlds.

1330. *Sir Hugh Watson:* You would be eating your cake and having it?—We would be eating our cake and having it.

1331. *Professor Jewkes:* You would not have the central pool?—As long as in the aggregate the amount to be divided was not less, as long as there was the proper amount produced by Spens plus the proper betterment, that would be fine. But I cannot conceive of the Government accepting that principle and paying us what you might call a fixed

sum for capitation fees and loadings and then saying "now here is a fixed sum for capitation and loadings but we do not care what you do in respect of the remainder of the items in future. You go ahead and do what you like." I can see dangers here from the Government's point of view and I can see that the Government would be unwilling to do this. After all, we are a reasonable body of people, we try to see the difficulties for the other side as well as our own. Our only trouble is that the other side do not see our difficulties.

1332. If the Government were not afraid of this scheme, you would not be afraid of it either?—No, as long as we were assured that the total figure involved was not less than that recommended by Spens, not less than the net figure recommended by Spens with proper betterment up to date.

1333. *Sir David Hughes Parry*: May we come back to the size of cake shortly. I am concerned at this point with the distribution, with the cutting of the cake. Spens, in several of the recommendations, deals with the cutting of the cake. There is no question about it and the interesting thing is that the cake has not been cut quite in the way that Spens indicated because you have agreed that it should be cut in a slightly different way, is that right?—We do not know. We do not know how near we are to the Spens indications, but the Spens Committee quite definitely indicated certain things. For instance, that only at a certain age did they make certain recommendations. It also said:

"We anticipate that the general introduction of a publicly organised service would have the effect of levelling up to a considerable extent."

Even in that very narrow field of those aged 40 to 50 where there is a specific recommendation. Even there they were qualifying it in the context of their report to some extent because they said "even this might be levelled up in some way". Spens did not set out a precise table of recommendations throughout the ages of a doctor's life in terms of percentages and the sizes of practice he was to achieve. He just said that here is the basis. If you take the actual years of an average doctor's life we expect that as a result of our recommendations—which, in point of fact, are the ingredients of the cake—we expect that you will

be able to cut up a cake in respect of these men more or less in these proportions. In a nationally organised service we expect the cake to be flattened out a bit at the top, or whichever way you look at it. Is that not what has been said about distribution?

1334. No. I thought that we had gone together through these recommendations very carefully this morning and tried to make clear which of those recommendations relative to distribution had been implemented and which had not. The interesting thing is that you are rather receding, if I may say so, from the position that these recommendations as to the cutting of the cake are hindering. You have agreed that one of them could not be put into effect at all. With some of the others you have made an effort to put them into effect but although you are not quite certain whether you have succeeded, you have done your best. But you are quite prepared to see the recommendations as to distribution departed from in certain cases. Is that right?—Yes, within the general framework of the intentions. Actually I do not think we ever have departed from these. I think the effects of the increases of Spens in 1946 or 1947, with the impact of the National Health Service in 1948, followed by the changes that took place as a result of the Working Party in 1952 will be found to have resulted in roughly this sort of thing.

1335. *Chairman*: You have said yourself that there has been a departure at the top?—There has been a departure at the top. The profession has been satisfied to agree to this. In order to deal with practices of a lower size which they felt needed some addition the men at the top have accepted the elimination of an increase in order that there may be a larger sum available for those below the top level, mostly in the intermediate level but in part at the very bottom in the form of initial practice allowances for those who were just entering practice.

1336. They have done this by accepting a limitation on the number of patients they can handle.—If the top level had remained at 4,000 then those at the top of the list would have had a lot more money and looked after more people. They accepted this limitation of 3,500 and in point of fact the money thus saved—I cannot quote the precise amount it came to—but a lot of it was

used for loadings for those with lists between 500 and 1,500 in order to increase the incomes at those levels where it was felt that doctors were doing a first class job of work in the National Health Service. It was felt that those were the incomes that in the light of modern-day conditions were most in need of increase.

1337. *Professor Jewkes*: This is something of a repetition, Dr. Wand, but I just want to press this point a little. It seems to me that the present situation is a challenge both to you and to us. We had a case quoted to us last week that doctors are being called upon these days to do a great deal of inoculations for polio?—Yes.

1338. As a result of this those doctors who are doing most of this work will find at the end of the year that their earnings have increased. But they are doing this extra work with the knowledge that as a result of that extra effort the capitation fees of other general practitioners will be reduced. It seems to me so irrational that increased effort on the part of one lot of doctors should have the result of reducing the payment of other doctors.—The injection for polio is part of our terms of service. We do not get paid to immunise against polio. It is part of our job to do this sort of thing.

1339. *Sir Hugh Watson*: May I make a slight correction. The charge in question was not given to the doctors for doing the injections but for notifying the local authorities.—For notification, so that in terms of doctoring it is just part of our ordinary terms of service. We have accepted that. Notification is the thing for which payment is made. It so happens that we do get paid for notification and it simply means that there is a slight re-distribution of the pool in respect of that very small amount relative to the total size of the pool. Under that re-distribution some doctors get more and others get less. In point of fact it is not re-distribution of the capitation fees; these are fixed. It is a re-distribution of monies which are taken from the rest of the pool.

1340. *Chairman*: Yes, but it is a re-distribution of what would have been distributed as the balance at the end of the year. So it is really a re-distribution of the capitation fees.—It is a re-distribution of some of the monies due to a doctor in respect of the work that is done. If the man does one hundred polio

injections he will as a result get a slightly larger sum of money than the man who does less, but it is, as I say, a re-distribution of monies in respect of work done—that work being so far as the actual clinical side is concerned, part of our terms of service.—*Mr. Holmes Sellers*: And there is equal opportunity to undertake the service.

1341. *Professor Jewkes*: In some cases there may not be equal opportunity. In the case of polio, perhaps, yes. In other cases, no.—I meant polio.

I was hoping to have an answer, but maybe there is no answer here. I was hoping to find some possibility of getting over this particular difficulty where apparently you penalise one section of your profession when another section works harder.

1342. *Chairman*: But in any case you feel that this is on the fringe, it is a small part of the total?—*Dr. Wand*: It is a small part of the total.

1343. I think there are other things we want to talk about that are not so small. The capitation fee under Spens is a gross fee, is it not?—Yes.

1344. Covering expenses?—*Dr. Davies*: Oh, yes.

1345. A net remuneration in addition to practice expenses. You all know that this has been very much challenged as a system by other people. Do you think it is a good system?—*Dr. Wand*: I think it is a good system. It has worked for a long time. The fact that it has worked for a long time is not proof of that, but I think it is as reasonably fair as any other system. Taking the overall life of a doctor I think you will find that over the years he will have had a fair crack of the whip on the percentage of the expenses. When he starts, if he starts in one of these designated areas, he gets from the pool a sum of money to help him along the first three years. This should huffer him to some extent against his vastly increased expenses.

1346. He receives the initial practice allowance?—He receives the initial practice allowance.

1347. *Sir David Hughes Parry*: Has that been changed?—It only started with the Working Party.—*Dr. Davies*: There was a fixed annual payment prior to the initial practice allowance.—*Dr. Wand*: The two were worked rather

differently. I do not think you will want me to go into details.

1348. No.—As a man goes through his life there will be periods at which his expenses will be higher and periods at which his expenses will be lower. If he has to take an assistant, his expenses will be considerably higher because he has to take an assistant if and when his list goes in excess of 3,500. For the small increases to 3,700 or 3,800 he will get only a couple of hundred extra capitation fees and have to pay for an assistant. His net income will go down. Presumably the assistant will take some work off his shoulders but his income will go down. The same situation arises where a man takes a partner. There will be all sorts of other situations in which a man's expenses will go up or down in the course of his professional life.

It is often said that the man with a big list or multiple practice is the one with the small proportion of expenses. That is not always so. In one such practice I happen to know that the expenses in 1955-56 were 47 per cent. of the receipts. So that it does not always apply that these high ratios of expenses occur only at the lower levels. But as a man goes through his professional life building up his list, if he is a good doctor retaining his list and then tapering it off as he usually does at the end of his career, I think it will be found that as a rough and ready method this is as good as can be found. The alternatives are difficult and here again I do emphasise the fact that we are not an unreasonable body of people trying to get something to which we have no right. If we went to the Government and asked them to allow us to draw what amounts to expense allowances ad lib it would be entirely unreasonable.

1349. *Sir Hugh Watson*: Surely these expenses could be controlled, Dr. Wand?—*Dr. Davies*: It is very difficult.

Sir Hugh Watson: I know it is. Could we have a few words on this? You have no doubt seen the figures which were produced by the Inland Revenue for the first quarter of 1953. As you know, the average expense which is included in the figures about which we are all talking is 33.4 per cent. You have your gross remuneration of £3,333; you deduct £1,111 and you get the magical figure of £2,222. The

figures produced by the Inland Revenue for these months of 1953 show that the average expense ratios varied from 44.39 per cent. in practices of 3,000 and over with an assistant, down to the lowest one which was 28.57 in the case of partnerships of three partners in urban areas. What has been strongly suggested to us from another source was that these expenses apply most inequitably and that, in fact, there is an inducement to doctors not to spend on their ancillary help, on their surgeries, on their equipment and so on, the sums that they ought to spend, because their expenses are not treated in the proper way, because if they do that they will land themselves with an expense ratio of 44. In point of fact they will be paying the tax on the income which they have, in fact, used for expenses. It has been strongly suggested to us that some system could be worked out under which, with proper supervision, through the committees of which you are aware, a recognised plan could be laid down by the Ministry of Health, who as you said already are not unreasonable. In this way this system of expenses could be made more reasonable. Of course we all know that what is most important today is net income.

1350. *Chairman*: May I come back to one point that Sir Hugh mentioned about paying tax on income that they have not received. I think that they only pay on actual income, whatever their expenses are.—*Dr. Wand*: I have Sir Hugh's point. It is the difference between 44.4 and 28.7. Sir Hugh's suggestion is, of course, a most attractive one. Suppose every doctor in this country in the National Health Service knew that he could spend any reasonable sum he wished on his equipment, his practice premises, his car, his ancillary staff. Even with what is called supervision by the Ministry—which I do not quite understand because it would mean having one snooper to every two or three doctors' surgeries to find out how they were spending their money—I think that the Service would cost the country a great deal more. I think it would be an encouragement to a doctor to spend more, whereas now he knows he spends his own money, he makes his ordinary application to the tax man for a tax relief in respect of expenses and these figures are ultimately going to be thrown up at an inquiry.

such as we have made from time to time by the Inland Revenue. I think we are saving the country considerable sums of money. I think when everybody knows that all they have to do is put in a claim at the end of a certain time for repayment of that specific sum, you would get a very different thing from the present method. If Sir Hugh's method commended itself to the Government, and as long as we got our net remuneration from Spens with the full betterment, we should not resist it. We would like it. But I am not going to make a plea for it because I think it would cost the country more money.

1351. *Sir Hugh Watson*: Dr. Wand, I would not like you to think it was my suggestion. It was made to us in evidence.—I am sorry, Sir Hugh.—*Dr. Davies*: May I refer to these tables. You take a set of figures on these tables and draw certain deductions as to expense ratios; I think 44.39 was quoted as the highest and 28.57 as the lowest. That is a reasonable deduction for the circumstances obtaining at the time these figures were prepared. But the position of the doctors concerned at that time is only a snapshot in life and each of those doctors or groups of doctors will be on different lines in five or ten years' time. I want to give you the impression that while a doctor who is starting with a small list may have a relatively high expense ratio, throughout the whole span of his career it does average itself out reasonably.

1352. *Chairman*: That is what we would like to know really. Such individual evidence as we have had so far has been that there is this very wide variation in expenses that does make a tremendous difference to the net income received by doctors with approximately similar lists and practices.—*Dr. Wand*: That will be so, Sir Harry, there will be wide discrepancies. I would not dispute that. There may be wide discrepancies in certain individual cases throughout the whole of their lives. They may be getting too little or a lot too much. I would only say by and large it would be difficult to find a scheme any better than this that would not be more expensive to the country.

1353. We may have to try and find a better scheme.—As long as the net figure is right we would be very pleased to study it.

1354. Dr. Wand, there is some reason to think that if there are some doctors who are always having too high expenses as a percentage of their gross takings they will tend to be the doctors who offer rather more facilities, take longer over their patients, have better surgeries and vice versa. So there is some evidence to suggest that the average expense ratio encourages mediocrity in service. That is bound to be found.—I would not associate myself with that. I would not associate myself with that at all. There are all sorts of factors involved. One doctor may have his surgery at his house. His family may give a considerable amount of help to him for which he makes no claim except just the very small claim that he is allowed to make—I do not know what it is now—in respect of income tax relief, although his wife may be giving absolutely full time to the practice and more than full time. His expenses may appear to be unduly low. He may be giving an absolutely first class service. His whole family is giving a service. There are so many differences and throughout the whole of a doctor's life there may be differences. Another factor is now cropping up which is not making the problem any easier, and that is the re-development areas. A doctor who is in an old house in an old area may be paying a rent of £50 or £100 a year. That is all the Inland Revenue has to allow in these figures and the country has to pay, so to speak, through the expenses for this doctor. But where that house is being pulled down and being replaced by one put up by the local authority, where the local authority is refusing to allow the doctor to build and so preventing him from getting the advantage of this special fund which comes out of the central pool, it is known that in some cases the rents have gone up to nearly four figures. There may be discrepancies of that kind. I think we would welcome you having a look at this problem to see if anything can be done. I do not know but it may be that over the whole of some of these doctors' lives even these increased rents, set against the previous low rents, may put them level pegging with others. There are a lot of swings and roundabouts, a lot of difficulties.

1355. *Sir Hugh Watson*: Dr. Davies did mention that one of the things thrown up by this was the fact that the younger doctor would be hard hit in his

initial years and he went on to say it could be even harder as he got older. Would not that be a substantial deterrent to a young man starting up practice? The case given to us was that a doctor with 1,100 patients, a gross income of, say, £1,650, and an expense ratio 8 per cent. higher than the average, loses £132 per annum.—Loses?

1356. Loses; his expense ratio is 8 per cent. higher than the average.—You mean that he loses on expenses?

1357. Yes. Another doctor with 4,400 patients and a gross income of, say, £6,600 and with an expense ratio 8 per cent. below the average gains £628.—Did this doctor have an assistant?

1358. He must have had otherwise he would not have had that number of patients.—There have been odd cases in which doctors in certain areas have been unable to get assistance. I would like to know the details. A doctor may be without an assistant for several months because he may be in an area where he cannot get assistance at any given time. The doctor with 1,100 patients is losing, but if he continues he is going to go through the mill as an average doctor establishing himself; his list will grow to 1,300, 1,500, 1,700 and there will come a time when he gets to 3,000 and when he will be 8 per cent. below the average expense ratio. I would like to follow the doctor right through his life in order to be sure. Dr. Davies has used the word snapshot. I am speaking of a film from which you are taking one still at a time.

1359. *Professor Jewkes*: Could I ask Dr. Wand—I am sure it is as he says—that if there were a system by which doctors were reimbursed for their expenses and no questions asked, of course there would be a lot of waste. But do you think that under the existing system not enough is spent on surgeries and facilities and so on? We have had complaints of that kind.—I think more could be spent with advantage. I think some doctors do spend less than they would do but, here again, it is a question of the money available. After the Danckwerts award there is evidence that doctors spent considerable sums of money on re-doing their practice premises. There were alterations, renovations, and quite a lot of rebuilding. The Danckwerts money was used, and being capital expenditure none of it was reimbursed in the form of

income tax relief. That is an important factor in dealing with these problems, the question of income tax relief on capital expenditure. That money was spent in that way. I believe that had the proper betterment been added to our remuneration during the years since Danckwerts that more money would have been spent. I believe that the reason why less money has been spent is that the doctors have not been properly paid. I think it is as simple as that.

1360. *Mr. Bonham-Carter*: Dr. Wand, do you think it is true to say that by accepting this method you have described to us, you are, in fact, accepting a system which hits the profession where it hurts most? That is to say, the young man coming in to begin practice?—We have tried to deal with that in certain ways. The young men coming in get in in three ways. They get in by taking a partnership in which case they are assured of a reasonable income right from the beginning; or they get in by getting a vacancy and the vacancies that are advertised are usually sufficient to allow a prudent man who is careful in his first years—as careful as we all had to be in our first years before the National Health Service and before the war—to enable him to carry on. There is the third man who gets the initial practice allowance.

We have tried to help that man in two ways. We have indicated to him the area in which we think he can build a practice up; and we help him additionally by giving him from the pool a sum of money for three years to enable him to buffer himself against his expenses. In no walk of life is anybody expected to go into anything without a penny at all. They have had a certain amount of training and in the old days they used to save a bit of money. This is one of the snags. During their hospital period they are so badly paid that they do not really save money, they owe money when they come out in many cases, or have used up their meagre savings. So the young man's lot is made much worse because of the preliminaries that go to his entering practice. If he goes into a designated area his chances of building up a reasonable list within two or three years are quite good. They are designated for that reason. That also applies in some of the new estates. I am not saying that these are the usual

cases but in some of the new estates some of these young men have built up very successful practices in a comparatively short time.

1361. *Chairman*: What proportion of new starters go to designated areas?—I do not know.

1362. Would it be one-quarter?—I just do not know.—*Dr. Davies*: I will try and find out for you, Sir.

1363. I just wanted to be sure whether we were dealing with the usual way of entry, or not.—We could provide you with this, assuming it is available.

1364. I was very interested in what you and Dr. Davies were saying. That it is a mistake to take a standard; that over a period of ten years people will vary a good deal and it will average out about right. We have not had any evidence about that; no evidence to the contrary because this point is a new one. I would like to have some further evidence because it has been suggested to us indirectly, rather to the contrary, that in many towns it will be the practices giving rather hasty, shoddy doctoring that are getting the largest lists, that therefore have the largest expense allowances and yet are spending least on expenses; and that there are other doctors doing very conscientious work with more than the average expenses. If that is not so we ought to know it.

By the way, I see the answer to the earlier point is about one-sixth. About one-sixth of new members enter practices through this designated area method.

On this other point, Dr. Wand, you are making a very important statement that over a period of years the 33·4 per cent. ratio, or whatever it may be, balances by and large?—By and large.

1365. Can we get some evidence to that effect, please?—I do not know that we can. I do not know that we can produce evidence of a character which would satisfy the statistician. The interesting feature of the statement that was made by Sir Hugh Watson is that of the two extremes, one is only one-third above the mean, and the lower one is less than one-sixth below the mean.

1366. Those were extremes of averages, they were not extremes of individuals.—Even so as extremes of averages for the quite large number of groups involved they are not so wide as

one would have thought, as one of the groups would be concerned with these very small lists. I should have thought that, by and large, over the years the average was satisfactory. You may get a bad case, I agree—you are bound to, with 20,000 doctors—but by and large I should say that the average works out over the years. But I can only repeat what I said before, Sir, that if you find a scheme which will give us the net remuneration of Spens with proper betterment, and a completely free hand on practice expenses, who would we be to refuse such a thing?

1367. That may not be the answer but we would still wish to have, if we can, some actual evidence about what does happen to these doctors who are at one stage having a very much higher than normal proportion of expenses. You see, supposing a doctor is getting £3,333 gross—and we are rather talking in many cases of the doctors who are getting a bit less and who would, therefore, have the higher proportion of expenses. The average expenses on £3,333 is £1,111 but if instead of being 33½ per cent. this doctor's expenses are say 45 per cent. They would amount to about £1,600; which means that instead of having £2,200 net he will get about £1,700. It is a very considerable difference.—The figures are not as big as that, are they, Sir?

1368. I think they are.—If there are any figures you would wish us to try to find, and you could indicate them to us, we will do our best. But we have always been a little bit unhappy about providing figures which were not approved by the statisticians as having given the proper picture. We can take an odd man here or there, and out of the blue might be able to indicate the £1,100 and the £4,400 man, but this would be of little use in the statistical sense. We could get a group of people together but the same accusations may be made against those, that they were just a chosen group of people whose figures are not sufficiently typical to be used. But if you could tell us with what information we can supply you, we will do our best.—*Dr. Davies*: Statistically it is almost an impossibility, starting from now, because you will have to pick out a number of individuals, regard them as pilgrims, and discover what the pilgrim's progress throughout the year

is; but the Royal Commission cannot wait that long. The only way we can give you the impression is not by statistical evidence of any kind; it is by having regard to the reverse process. Dr. Wand and I are only two examples of the general practitioner, and we have both been through the mill for over 35 years.

1369. The last 10 years will serve for this purpose.—What I am saying is that it is retrospective opinion, experience, for what it is worth.

1370. *Sir David Hughes Parry*: We are very anxious that any method of remuneration should not constitute an incentive to the black sheep who, admittedly, are in every profession. We do not want them to make any money by not spending somewhere near the average on improving the facilities and the ancillary services in the practice. That is what we really want to do.

Chairman: It really comes down to money made at the expense of their colleagues.—*Dr. Wand*: I would like to take up this point, because after the Danckwerts Award we were determined, and we are still determined, that we shall do all we can as a body, in the General Medical Services Committee, to bring doctors' premises up to the best possible standards. I think that every general practitioner in the National Health Service had his premises inspected about three years ago. Then, if it was found that they were unsatisfactory in any way, the doctors were written to and asked to put them right. A second inspection took place later and, if the doctor had not carried out his improvements the matter was brought to the notice of the Executive Council. We did that ourselves. That was our own contribution to what you are referring, in some respects. The Executive Council has the authority of inspection of doctors' premises, and can require that to these premises certain things shall be done; that otherwise they will not be accepted. So that in respect of the premises themselves there is something in the regulations.

1371. *Sir David Hughes Parry*: There is a minimum standard?—No, there is no minimum set out and no maximum; it is entirely according to judgment.

1372. *Chairman*: The Cohen Committee has suggested that more should be done.—*Dr. Davies*: It was as a

result of their recommendations that we did that.—*Dr. Wand*: This is what followed the Cohen Committee's report.

1373. *Mr. Bonham Carter*: You use the term "a free hand with expenses," but I think what we had in mind was actual expenses.—I am not asking for the moon, and my colleagues are not asking for the moon. A man may be satisfied with a very small car for himself; but if he knows that all he has to do is to put in a chit to the Government, he may decide to buy himself a much larger car. Would the Inland Revenue accept a 16 h.p. car instead of a 10 h.p. or 12 h.p. car?

1374. *Sir Hugh Watson*: The Inland Revenue would have nothing to say.—Throughout that year the expenses of running a car would be higher. Whereas if the doctor knows he cannot go with a chit to the Government, he may be satisfied to spend less money on an item of that kind. I am not suggesting he would be inclined to spend less money on those things which are necessary—but in a matter of that kind how are you going to check it?

1375. *Sir David Hughes Parry*: Who checks it now?—There is no check now, except that the man himself does not get reimbursed.

1376. *Chairman*: He only gets the tax allowance.—He only gets the tax allowance. The expenses do come out eventually and are shown. But this is after a lapse of time; there is a psychological point there.—*Dr. Stevenson*: If he does buy a more expensive car he will not get the price of that car back, he will get one twenty-thousandth of it, because it affects his part of the final settlement. So it is a very real encouragement to economy in that sort of expenditure.

1377. *Chairman*: Dr. Wand, it is not simply on the question of premises that this has arisen. There are many other ways that have been suggested. For instance, one doctor may push a great many more people off to consultants and to the hospital service than another doctor, who may keep them and do much more of the whole treatment of the patients himself. There can be those differences in degree which may amount to a considerable amount. The doctor who keeps the smaller number of patients gets not merely less in salary, but also a lower contribution towards his

expenses.—*Dr. Wand*: I do not think this means such a lot from the point of view of expenses. This is a matter which could be discussed in another context. I can only say that a successful doctor is a man who gives a proper service, continues to give a proper service, builds up a large list, and retains that large list. I do not think such a doctor would fail to provide himself with all such necessary equipment and place of practice as would be necessary. There may be some occasions when there are some temporary difficulties, due to redevelopment, for example. But on this question of expenses I realise here that I am arguing for the Government.

1378. *Mr. Bonham Carter*: You are also arguing for one section of the profession as against another.—No, I am arguing on the basis of the overall average, the swings and roundabouts.

1379. You were talking about snapshots a moment ago.—I thought we had got past the snapshot stage.

1380. You were saying that at any given moment the system is favouring one section against another.—At any given moment the majority of doctors would not be on the average; I think that must be freely admitted.

1381. And by and large it is likely to be the younger ones who are at the wrong end of the stick?—It depends on the number of practices; it should not be for a very long time, and we have taken certain steps to try to help with the problem.—*Dr. Davies*: I have one point, Mr. Chairman. I should like to be satisfied that we are all talking the same language. Certainly outside this room there is an impression that all the doctors' expenses are allowed. That is not true. These practice expense ratios and figures apply only to that proportion of expenses which are allowed by the Income Tax inspector.

1382. *Chairman*: I think that is quite well understood here, at any rate. But it still remains that the method of paying a gross fee increases inequalities among net fees.—*Dr. Wand*: Temporarily.

1383. That is something we shall have to find out more about, because that has not been put to us before. Many people, as you well know, have considered that the method of paying expenses in with the capitation fees is not a good one.—I can only sum up that so long as

the ultimate purpose is a proper net payment to all general practitioners, they would be very willing to discuss any method of computing expenses which are produced by this or any other Committee. They are not bound to this method but they think it the only convenient and fair way they have been able to find yet.

1384. *Sir Hugh Watson*: At the moment, to sum up your position in the language which you have been using, the opinion of the B.M.A. is that so long as there is proper bettermenting you will get a cake such that you are perfectly happy with its distribution, and also with the proper method of dealing with the expense of cooking it.—*Dr. Wand*: I do not know what you mean by the expense of cooking it.

1385. To follow on *Dr. Davies'* point, if it does make it clear, the average doctor is in fact paid £3,333, and he then has to go to the Inspector of Taxes and justify his expenses.—Yes.

1386. *Mr. Gunlake*: You will have gathered from the series of questions on expenses that we have in this Commission received a number of complaints from individual doctors that their expense ratios differ markedly from the average, some of them in the region of 50 per cent., or 60 per cent. Could we ask whether such complaints come to the ears of your Council?—They would not come to the Council, but perhaps *Dr. Davies* has received them.—*Dr. Davies*: I have never had any brought to me as high as that.

1387. I was asking about complaints from individual doctors.—*Dr. Stevenson*: We have had letters on the subject from time to time, and I think when a full explanation is given as to how it works—the swings and roundabouts, etc.—the explanation is readily accepted.

1388. *Chairman*: *Dr. Wand*, you will know that in Table B, on page 5 of Spens, it is actually proposed that 7 per cent. of the doctors would be getting, after allowing for betterment, an income of up to £1,400—I think £1,475 at present—and that means that on the 33 per cent. expense ratio expenses would be about £500. Are there many doctors who could conceivably manage with total practice expenses of £500?—*Dr. Wand*: It depends where he is living—if he is in practice at home.

1389. I was just asking. I am taking that figure from Spens, because that is obviously one of the things that concern us.—I would not like to answer that off the cuff. I would like a little time to work out some figures.

1390. We said we would finish about half-past four, so perhaps you could work out the figures before tomorrow. We will be wanting to go on a bit further on parts of this question because there have been no other methods of payment suggested, and we do want to arrive at a proper conclusion.—We will work out some figures overnight.

(The proceedings were adjourned until the following day)

Friday, 24th January, 1958

On Resumption

Chairman: Now Sir David would you like to start off again?

1391. Sir David Hughes Parry: We are still concerned with distribution and one or two other matters which we did not quite finish. We are placing, as you realise, very great emphasis on this because, after all, the Spens Report recommendations were very largely concerned with the question of distribution. It has been very strongly represented to us that there is a certain amount of discontent and unhappiness at the methods of distribution. I will refer to that later on and give you certain quotations. Some of the evidence that we have received seems to indicate that there is some support for a full salaried service and we would like to hear what you have to say on that suggestion.—Dr. Wand: You mean on the general suggestion of a salaried service?

1392. Chairman: Of a salaried service for general practitioners.—The profession is against it. I want to make that abundantly clear—the profession generally is against it. Representative bodies time after time have indicated their opposition to it. There are a number of reasons. I do not know whether you have the report of the Medical Planning Commission, for example, in which some of these reasons were set out. I do not know whether you want me to go into the details, but we are an independent profession, and if I can put it as nearly in a nutshell as I can,

we prefer to work for the patient rather than for the Government. The recent relationship to the Government on this particular matter has certainly not increased our anxiety to be placed under governmental control.—Dr. Davies: May I add to that, Sir? There is the financial matter. It would be extremely costly for the Government to provide the surgery premises or health centres for the whole of the general practitioner medical service at the present time. General practitioners do own their own premises and all their own equipment.

1393. Sir David Hughes Parry: And under a salaried service I take it the premises would have to be provided by the Government?—Yes.

1394. There are certain places where there are these health centres?—There are a few health centres.—Dr. Wand: I do not know whether you want me to elaborate this at all. I should have thought you would have wanted very little elaboration. We have certain fears which I think are not ungrounded.

1395. Chairman: We wanted to get the B.M.A.'s views on this suggestion which has been made to us from other quarters.—We are absolutely against it. It will eliminate completely in our opinion the freedom of choice of the patient. There will be direction of the doctor, all sorts of factors, and I think the net result in this country would be a complete disaster for medicine.

1396. Just one further question on this I want to ask you, Dr. Wand. It has been put to us that it is particularly the older generation of doctors who dislike the departure from the previous established traditions and methods, and that the younger doctors on the whole are more favourable. Would that be contrary to your impression in the B.M.A.?—Yes. I have been very much impressed by the remarks of the younger men in practice. We have, as I indicated yesterday morning, a young Practitioners and Assistants Committee and that Committee is against a full time salaried service.—Mr. Holmes Sellers: May I just add, Sir, though I do not think it is within your actual question, the hospital side would endorse precisely what Dr. Wand has said in all respects. They hold very strongly that a whole-time hospital service would be disastrous so far as the medical service in this country is concerned.

Sir David Hughes Parry: We wanted to give you the opportunity to make your reply to these other submissions.

1397. *Chairman:* I think I must follow up what Mr. Holmes Sellers said. I understand at present the profession is divided into two main branches, one of which is the hospital service, which is basically salaried and the other is the general practitioner service which is basically capitation fee. I do not think you are suggesting the hospital service should depart from that?—No, I do not. All I was trying to imply was that a whole-time salaried service for the hospitals would be in our view a disaster.

1398. I think, Dr. Wand, your comments apply to a salaried method for G.P.'s, whether whole-time or not whole-time?—*Dr. Wand:* Any element of salary in the remuneration.

1399. I appreciate that you find the great body of your members prefer the present system, but it must be there are some who do not?—We are a profession of individualists and in certain circumstances a man may feel impelled towards a particular thing but when he realises the implications we find that he is dead against it.

1400. You would say it is a small minority?—I would say it is a small minority and I would say even that small minority to a large extent changes its opinion when the realisation of the implications of full-time service is brought home to them.—*Dr. Stevenson:* Dr. Wand referred to our own Assistants and Unestablished Practitioners Committee. He mentioned yesterday this is a completely democratic body. Its members are elected from assistants and young practitioners throughout the whole country—twenty doctors geographically elected. That Committee is completely against any proposal for a salaried service. I think it is fair to say that the great majority of young men would be against it.—*Dr. Macrae:* I think, Sir Harry, that the idea of a salaried service sometimes appeals to young doctors who, for some reason, are feeling themselves frustrated because they have not been able to achieve advancement in the profession. They see some hope in this idea. The fact that it may appeal to some doctors thus situated does not mean it would be a good thing for medicine.

1401. *Mr. Bonham-Carter:* I think, Dr. Wand, you and your colleagues have made your position very clear on this. I do want to ask one further question so I may understand what you mean by salaried service. Your original point was that the profession were against it, I think you said on the grounds there had to be a closer relationship between the patient and the doctor. You wish to retain that. In fact the payment you receive now, excepting that it is based on a capitation fee, comes from the same source as a salary anyway, does it not?—*Dr. Wand:* That may be so, but it simply means the Government signs the cheque, if I may put it that way. But it is the patient who decides whether he wants me or some other doctor; on the patient's behalf, the Government pays me. But in a salaried service there would be a number of other elements coming in—direction, decision as to how many patients would be allocated to a doctor in a particular place and which patients would be so allocated. A scheme was drawn up at one time by the Advocates of such a service in high places—that is to say towards the latter end of the war if I remember rightly—in which doctors were allocated streets of patients to attend to. Presumably in course of time when they received advancement, when they had got to know the patients in those streets, they were allocated streets in another town because they needed a doctor with more experience. It is a fantastic system.

1402. *Sir David Hughes Parry:* Another mode of payment has been suggested to us which still concerns distribution and is described as an item of service mode of payment. You have got that to some extent in one or two instances, now, have you not?—*Dr. Davies:* An item of service mode of payment could operate under any of three systems. There would be the one in which the State pays the whole of the cost. There would be a system which does obtain in some parts of the world today where the State pays a part and either the patient, or the patient through an insurance corporation, pays a part. The third method would be where the patient paid the cost entirely. I wonder to which of those three you are directing the question?

1403. The first or the second?—*Dr. Wand:* In theory the relationship

between two people in medicine would be most properly dealt with by an item of service payment. I think on that there can be little doubt. But in a National Health Service where everybody is entitled to receive any medical care that they need there are then obvious disadvantages to the State. If a scheme could be evolved to which the State could attach itself and give a proper item of service payment I think that would receive very favourable consideration indeed from the profession. But it has been tried out so far as the full item of service is concerned in the early days of the National Health Insurance Act; but it was tried out within a global sum for a particular area and it was dropped. I need not go into the reasons: I think they will be obvious.—*Dr. Davies*: There is a further matter, Sir, of importance to the health of the community, and that is continuity of treatment. On an item of service basis the patient can please himself where he goes at any time. It is not in the patient's interest to wander about from one doctor to another. Under the present system he is frozen as to choice of and acceptance by a doctor and is in receipt of continuous treatment and observation. Thereby early diagnosis is made and continuing observation and treatment are obtained. Those advantages are not necessarily obtained in an item of service scheme.

1404. *Chairman*: Dr. Davies, before the National Health Service came along, when patients were private, they could I suppose change their doctor if they liked?—They had that freedom and in fact they have that freedom in a capitation system. The very fact they are on the list of a doctor in the majority of cases means that there is continuity.—*Dr. Wand*: They have the right of change. The patient can change if he is not satisfied with his doctor.

1405. In the majority of cases there would have been continuity of care even in the old days, would there not?—*Dr. Davies*: That is so, but the inclusion of a fee did imply a break in early consultation.

1406. *Mr. Watson*: That might be so if the State pays the whole of the item of service. If not, should it be any more easy for a patient to change from one doctor to another than it is at present?—Except that capitation means regis-

tration. There are also the factors of record keeping and indeed of book-keeping. Now under the item of service system book-keeping would be a tremendous matter.

1407. *Chairman*: I take it Dr. Davies that the objections that the B.M.A. would have against an item of service system are not so much based on this point, whether the patient is foolish enough to change from one doctor to another, as on some of these other matters?—*Dr. Wand*: I think the crux of the matter is purely one of finance. I think if the Government said to us: "We do not want to pay you a capitation fee but on an item of service basis—we do not care how much it costs"—I think we would accept, but would the Government be willing to do that? As I indicated on certain subjects yesterday we realise that this would mean a sum of money which could not be anticipated even month by month. But I would attach importance—I am sure my colleagues would do the same—to an item of service system if it could be devised. But if you are going to devise it in such a way as to give the whole of the population the full rights of medical care that it has under the present National Health Service, and devise it within a ceiling of payment, then I think the capitation fee has many advantages over it.

1408. *Sir David Hughes Parry*: But there would be administrative difficulties?—I do not think there would be any administrative difficulties; I think the difficulties would be financial. But if you think it is possible we can look at this again later. The point we have always made, as I say, is that if we are working within a ceiling the capitation fee is preferable; if there is no ceiling we will be reimbursed.

1409. *Chairman*: I do not think we need ask you to look at it again, especially at present, Dr. Wand.—As a matter of fact there is another point of course which is being looked at by the Association and that is something analogous to the Australian and New Zealand scheme whereby there is an item of service payment of which the Government pays a part. Dr. Davies has already indicated this. There is a sort of tripod. There is one payment by the Government, one payment by the insurance companies and one payment by the patient. In one country—I think it is New

Zealand—insurance for certain sections is compulsory. I am speaking from memory. I am not quite certain of my facts here but in Australia it is not compulsory to become insured.

1410. I think we can leave that where it is for the moment. We have not received much detailed evidence on this point yet. If later we find some important omissions we might have to ask you to look into it further.—We can give you information as to how these services do go on in other countries. We do have information.

1411. *Sir David Hughes Parry*: That would be helpful.—Would you like New Zealand and Australia?

If we have Australia and New Zealand it will be sufficient.

1412. *Mr. Watson*: The system does apply in dentistry?—Yes.

Chairman: Dentistry is entirely on an item of service basis.

1413. *Sir David Hughes Parry*: I do hope we have made this issue clear. We have given all this time to methods of distribution, because we have received evidence pointing to some discontent in the profession. May I just read one sentence from this evidence? It is this:

"The majority (of general practitioners) are however suffering from a sense of grievance derived, not only from insufficient earnings, but from a recognition that the funds available are being distributed in an inequitable manner."

There is some evidence suggesting to us that there is a good deal of unhappiness at the arbitrary manner in which the cake is being cut, if I may come back to our illustration.—I would like to know what is an inequitable manner. Is the present method inequitable? Is Spens inequitable? If so, for what reason? I have heard this statement made many times, of course, as you would expect. I would like more details of the actual inequity. I wonder, Sir, if you have more details to which I could perhaps reply?

1414. I have not got any details but this general statement has been made. I wondered what your reaction would be. You realise we have to probe the matter having regard to the statements of this nature that are made?—I can only say this, that if the general broad handing indicated by Spens has not been fulfilled

as revealed by your figures, or in any other way within the global sum available, just as we were willing and anxious to try to rectify matters in the Working Party so we will be willing to do so again.—*Dr. Davies*: I was about to add, Sir, that we do try within our democratic machinery to deal with these complaints of inequitable treatment, and every doctor has the right of representation. I am referring to the general practitioner now. He has the right of representation through his Local Medical Committee and through the Conference and these claims are very fairly heard. If there is any substance in them we do, as I indicated yesterday, go to the Ministry and, between us, we do hammer out some fair method of redistribution on a particular point. There is another example, for instance, which I did not quote yesterday, namely, the temporary resident fee. That is a device for paying doctors when a patient who is travelling or on holiday is taken ill or has an accident in an area which is not his own area. This system also applies at the holiday camps to which I did refer. We did have some representations that one stage of the temporary resident fee was inequitable, and in consultation with the Ministry we did obtain an improvement in that respect. I also referred yesterday to the fact that the Central Mileage Committee is sitting now to reconsider and readjust the position of the rural practitioner as regards his mileage payments. Those are examples of the kind of situation with which we do try to deal democratically.

1415. *Sir Hugh Watson*: I do not want to take up time over this. We discussed all these matters yesterday. What the people who made the statement complain of is in the first place that there is no variation in the method of payment for the work load. There is no recognition of merit. There is no recognition of experience. Further, it is said it is not equitable that the division of the pool should be by means of capitation payment when all these other payments can have the effect of making the range huge out in another place. These are the reasons, I think. We discussed them all yesterday.—*Dr. Wand*: Some of them we promised to look into again.

1416. *Sir David Hughes Parry*: Before passing on to the central pool I think I would like to ask this. I am

not quite clear in my own mind as to whether the Spens Report was intended to be an operation once and for all, that is, to get the profession into a national and properly organised Health Service on a fair footing; or alternatively whether it was an operation to get the medical profession into the National Health Service and then to apply the principles of the Spens Report for ever after. Those are the two possibilities as far as I can see and I would like to hear, having regard particularly to the problems of distribution, what view you take.—Now, Sir David, of course we are getting to the matter which is contained in our case as presented to the Ministry.

1417. We are on the borders now.—Yes. Before we get over the borders into what you might call the legal field, may I as a layman with no legal knowledge at all, indicate our view? Paragraph 6 of Spens makes it abundantly clear to me, and it did to the profession. If you look in the last line but one of paragraph 6 you will see the words "will be maintained". The dictionary definition of the word "maintained" is "to keep up, to carry on and to cause to continue in". That is the Oxford Dictionary definition of the word, and you cannot carry on or continue in something unless it goes on beyond a certain point. If it is maintained that the word does not mean that, if you feel that perhaps it may not mean that, you have only got to go to the previous line and you will see the word "changes" in the plural. I am quite certain that if these words were intended to mean only what you call a "once for all" that that word would not have been "changes"—it would have been "change". That is my interpretation purely as a layman, but there is an interpretation which goes of course more deeply than that. In a moment I am going to ask Mr. Cooke to speak on this matter. He of course can deal with the matter contained in our evidence. We have now gone slightly over the border on that point but I think Dr. Macrae wishes to raise something.—Dr. Macrae: I want to say I think it is expressed even more clearly in the terms of reference of the Spens Committee—"the desirability of maintaining in the future . . .". The future did not come to an end on 5th July, 1948.

1418. What we are after are your submissions on this matter. You realise that?—Dr. Wand: I think, Sir David, we can consider we are over the borders now into the legal field.—Mr. Cooke: Of course, the Spens Report has been looked at by a number of lawyers. I think I can begin by saying this, that the overwhelming and I think unanimous consensus of legal opinion is there is not the slightest doubt that the recommendations of the Spens Committee envisage continuous adjustments to the global sum available for remuneration and in the light of the two considerations set out in paragraph 6 of the Report. There are two major considerations which lead to that conclusion. The first is the one which has been mentioned by Dr. Macrae, namely, that the Spens Committee were instructed to frame their recommendations having regard to the desirability of maintaining certain desiderata which were expressed in the terms of reference. That is the first consideration. The future, as Dr. Macrae said, did not come to an end on 5th July, 1948. The second, of course, is that the language of the recommendations themselves indicate quite clearly that the intention was that these two desiderata should be maintained. The first is that the money available for doctors for remuneration should be adjusted according to changes in the value of money, and the second is that it should be adjusted in the light of increases in the income of other professions. Those are two conditions and they each require to be fulfilled independently of the other. One can see why the Spens Committee reported in those terms. Of course, if the global sum was not adjusted according to changes in the value of money, then the very object which the Spens Committee obviously had in mind, namely, maintaining the doctor's status, his freedom from financial anxiety, would not be attained. Obviously what the Spens Committee had in mind was that if the value of money is to fall it should not lie in the Government's mouth to say: "We are not going to make an adjustment because look how badly the barristers are doing or how badly the clergymen are doing." The Government was to be put under an obligation to make adjustments according to changes in the value of money independently of what was happening to the other pro-

fessions. Separately from that there was the obligation to make adjustments according to increases in other professions, and the reason for that again is obvious. It is given in the Spens Report. If you did not make adjustments according to increases which occurred in other professions, then of course you would be impairing the recruitment and status of the profession. So there were two requirements which had to be satisfied each independent of the other. You must keep up with changes in the value of money and also increases in other professions. One can see why they wished these requirements should be met.

1419. You would agree, would you not, that the recommendations in Spens are the vital things?—Certainly.

1420. Can you point out anything in the recommendations themselves to support this? That is what I am after.—I wonder if you would look, Sir David, at Appendix VIII—the supplementary case which the profession put to the Ministry? It is on page 3, paragraph 13. I think that really is the answer. It is in terms of recommendation (1) of the Spens Report which is set out.

1421. *Sir Hugh Watson*: You see, Mr. Cooke, it humbly appears to me that Dr. Macrae's argument on the use of the word "future" in the terms of reference is entirely destroyed by the famous words in Spens "We leave to others . . ." That takes away the argument about the future.—What Spens was looking for was a firm basis. The only firm basis for it was the 1939 value of money. What they said was that the basis is not to be undermined by future changes in the value of money which might work to the prejudice of the profession.

1422. *Sir David Hughes Parry*: They do not say it in the recommendations—that is our difficulty.—That is where I wanted to direct you. It says at the end of paragraph 1 of the Recommendations:

"Here also, as in the body of the report, we are expressing our recommendations in terms of the 1939 value of money."

Since this recommendation was expressed on that basis it is obvious that the two objectives of status and recruiting powers that the Committee desired should be achieved throughout the future would

not in fact be achieved unless there were in fact contemplated periodical adjustments or changes in the value of money and income. It is an inevitable result of that:

"Here also, as in the body of the report, we are expressing our recommendations in terms of the 1939 value of money."

That is the firm basis. Whatever is necessary to give effect to that is something which must be done.

1423. *Mr. Gunlake*: You have directed our attention to the terms of reference of the Spens Committee. These do refer to these two factors which you say have to be taken into account. But the words used in the terms of reference are "maintaining in the future the proper social and economic status of general medical practice. . . ." The words are not "maintaining in the future the status quo ante." Does it in your view mean the same thing? Do you consider the proper economic and social status means the status that existed at that time?—I would say the Spens Committee directed their attention to what was necessary to maintain the proper social and economic status of general medical practice. Their answer was: in order to do that we want, in terms of the 1939 value of money, these figures.

1424. *Chairman*: Mr. Cooke, is it your case that the proper social and economic status of general practice is an unvarying status?—I think it is one which the Spens Committee thought should be.

1425. I want to know whether it is your case.—It is a status which certainly should not be depreciated. I think I must accept that, Sir. It is an unvarying status, but it is certainly one which in any event should not be depreciated.

1426. *Sir Hugh Watson*: Whatever is the situation of barristers or solicitors, the value of the social and economic status of doctors should be maintained?—Yes. The Spens Committee may very well have thought it would be of the greatest public importance to maintain the social and economic status of the medical profession. The social and economic status of barristers is probably of far less importance to the community

in general than the social and economic status of the doctor.

1427. *Chairman*: You appreciated yourself what Mr. Cooke said about barristers, did you, Dr. Wand?—*Mr. Cooke*: I feel, Sir, the community gets the barristers it deserves. There are obviously dangers in allowing the social and economic status of the medical profession to be overlooked. That is no doubt why the Spens Committee were most anxious to have a firm monetary basis on which to anchor themselves. The last one they could find, very naturally, reporting when they did, was the value of money in 1939.

1428. *Sir David Hughes Parry*: I want to get the full implications of your submission. I wonder whether you would interpret Spens in this way: that in order to maintain for the immediate future the economic and social status of general medical practice, this sort of payment and this sort of distribution that we outline in our recommendations will be necessary; then of course if there are changes there will have to be made certain adjustments; but we are only concerned with the entry at the present moment into the National Health Service and we leave to others the adjustments. We are only fixing it at 1939 values and that is all.—I do not think they meant that. First of all I think if they had meant that they would really have been declining to act on that part of their remit to which Mr. Gunlake has just referred, the preservation of the social and economic status of general practice. Secondly, throughout their Report one finds phrases about the maintenance of the status of the profession which do indicate that they must have had something more in mind than a mere adjustment as at the moment when the profession entered the Service. It really would be rather astonishing if what the Spens Committee were really saying was: provided the doctors are offered terms which look attractive on 5th July, 1948, we do not care what happens to them afterwards. That is not really in my submission a very reasonable construction of the Report of a responsible committee. It is not consistent with their terms of reference and it is not consistent with the language they use in reporting.

1429. That is your submission. I am not here to argue the other way, but other interpretations are possible. That

is all.—I think I ought to add of course it is quite obvious that when Mr. Justice Danckwerts was considering this matter some years after the inception of the National Health Service, it never occurred to him for one moment that the only point as at which the Spens Report could be implemented was 5th July, 1948. It never occurred to him and indeed it was not even argued by the Government. On the contrary the chosen representative of the Government, their chief witness at the adjudication, made it quite clear that what he envisaged was continuing adjustments in the light of what he called major or important changes in the value of money. The passage on his evidence in this matter is stated in the documents. It is paragraph 20 on page 4 of this Appendix VIII, Sir. As you will see, the principal witness of the Government at the Danckwerts hearing was the Deputy Accountant General to the Ministry. What he says is this: I think it was in answer to his own Counsel—I am not quite sure.

"What I had in mind was this. After this adjudication was over (that is, after Danckwerts) and the adjudicator had given us a figure which he regards as an appropriate one for the Central Pool, then that figure would be taken as the basis of our pool payments and adjusted to take account of changes in the population year by year, adjusted at certain intervals which we should have to agree with the professions, because you cannot do this sort of thing every five minutes, to take account of a major change in practice expenses and again at intervals to take account of any future major change in, shall we say, the value of money. That is what I think we had in mind".

It did not occur to anybody; it did not occur to the Government themselves at the Danckwerts adjudication to put forward that limited interpretation, namely, one has got to put one's mind in blinkers, look simply at the position on 5th July, 1948, and ignore everything that happens afterwards.

1430. It was contemplated that of course changes will occur that will make it necessary to readjust this amount and this distribution from time to time. The interesting thing is that changes have occurred so far as distribution is concerned. You will agree to that, there

have been changes?—There have been some changes but broadly the profession accepts and founds on the broad banding of distribution which is to be found on paragraph 1 of the Spens recommendations in terms of the 1939 value of money.

1431. *Mr. Bonham Carter*: We do not know that has been achieved. —What Dr. Wand has said is of very great importance. We do not know that, but if it can be shown that broad banding is not in every respect achieved the profession will be happy to rectify it.—*Dr. Macrae*: May I draw your attention to Appendix III where you find the terms of reference of Mr. Justice Danckwerts:

"To determine the size of the Central Pool, after taking account of remuneration from all other sources received by general practitioners, in order to give effect to the recommendations of the Spens Committee . . ."

It will make it abundantly clear that as late as 1952 the Government accepted the view that adjustments in accordance with the Spens Committee recommendations should be made, that it was not a once for all.—*Dr. Wand*: May I add one word to this. The profession came into this Service under an interpretation of Spens such as I have indicated. Mr. Justice Danckwerts upheld that interpretation. The Government made no attempt at that time to dispute that interpretation. It seems to me a very strange thing indeed that because it does not suit the Government to adhere to that interpretation, they should not review that interpretation when they had the opportunity of reviewing it four years after the inception of the Service. They did not do so at that time. I should have thought that those very facts indicated quite clearly that the terms on which the profession came into the service were not only accepted by the Government at the time of Spens, but were accepted in our interpretation by the very actions they took or failed to take afterwards.

1432. *Sir David Hughes Parry*: We take your submission. I am not concerned to argue as you realise.—*Professor Allen*: I wonder if I can make a comment going back to the remit to the Spens Committee on maintaining in the future the proper social and economic status of general medical practice. I am very aware myself that this must not

imply that everyone is frozen for evermore in the position he occupied at a certain date. If you had that there would be no flexibility in the system at all. No one could get more money. They would go along frozen in the track. The crux of the matter seems to me to be the use of the words "proper social and economic status", which throws it back to the profession to maintain that their status should be maintained or indeed improved. I believe it to be the submission of the British Medical Association that the status of general practice should not be diminished but should in fact be improved. I think they would not accept any criterion that the status should remain frozen for evermore. I think they are claiming it should not depreciate because of that particular argument.

1433. *Chairman*: I think we understood that yesterday. Either an adjustment is made against inflation or an increase in line with other professions, whichever is the greater.—*Dr. Wand*: Otherwise if they had meant us to be associated only with changes in other professions there would have been no need to mention the value of money and other professions.

1434. *Mr. Bonham-Carter*: May I ask Mr. Cooke to intimate his interpretation of the words "should have direct regard" which occur in paragraph 6? That is paragraph 6 of the Report. What interpretation do you put on "should have direct regard"?—*Mr. Cooke*: It seems to me that "direct" used in this context must mean that the amount of money available for payment of the doctors should be directly related to the changes in value of money. In other words, that there should be some method by which changes in the value of money would be reflected without undue distortion in the money made available for the remuneration of doctors.

1435. *Sir David Hughes Parry*: We are going to pursue that further, but there is only one further question I would like to put. You have emphasised in particular the changes, the adjustments, that ought to be made in regard to the changes in the value of money. Now you insist that the Government should carry out its obligation to the full so far as that is concerned. Any question about that means also the provisions of the recommendations as to dis-

tribution generally. But these have been departed from. This is one of our difficulties.—*Dr. Wand*: But with great respect I will draw your attention again to that phrase of the Spens Report with which the Spens Committee itself indicated that to carry out precisely the suggestions made in their various tables in regard to distribution would not be possible when the National Health Service came in. They expected there would be certain changes. "We expect there will be an evening out", they said.

1436. *Chairman*: Will you just tell me which paragraph you are quoting?—Page 9. The first incomplete paragraph on the page, about half way down that paragraph:

"We anticipate, that the general introduction of a publicly organised service would of itself level up low incomes to a considerable extent."

So they did indicate that their recommendations were to be taken in that context.

1437. Yes. That is leading up to their general recommendations a little later on—their seven recommendations.—Yes. I am simply pointing out that we agreed, as I said earlier this morning, that if the general intention of Spens in regard to distribution had not been carried out, and is proved not to have been carried out, within the global sum, we would wish to look at it again.—*Mr. Cooke*: What is quite certain is that the recommendations of Spens cannot be carried out if the global sum provided is insufficient.

1438. *Sir David Hughes Parry*: The terms of reference of the Working Party, that is your Appendix IV, was:

"To secure an equitable distribution of the Central Pool based upon the recommendations of the Spens Committee . . ."

Presumably the object was to implement the Spens recommendations as to distribution?—Subject to the qualifying words which came at the end, that undoubtedly is so.

1439. *Chairman*: Which qualifying words do you mean?—"at the same time, to bring about a relative improvement in the position of those practitioners least favourably placed under the present plan of distribution . . ."

1440. *Sir David Hughes Parry*: You agreed?—*Dr. Wand*: We agreed that

the Working Party should look at this problem. But at the time of the adjudication it was made quite clear to us that if we did not agree to a Working Party carrying out this type of terms of reference there would be some doubt as to whether the adjudication would take place. In other words, we agreed to this Working Party with this type of terms of reference under—

1441. Under pressure?—Yes, under pressure.

1442. That is all I would point out to you, that the Spens recommendations do not seem to be referred to at all from beginning to end of the Working Party Report.—But the Spens recommendations were at the back of the minds of all members of the Working Party. An attempt was made to implement these recommendations as modified by group practice and small lists which were rewarded by agreement.—*Mr. Cooke*: That agreement does not in any way invalidate the main argument of paragraph 1 of the Spens recommendations.

1443. We regard the recommendations as one body from one to seven.—*Dr. Stevenson*: May I just say again that we are so much in the dark here. I do not think anybody in this room can say whether those recommendations have been fully implemented. And the same position applied when this Working Party met in 1952. There were no figures available. All one can say is an honest attempt was made to implement those recommendations as modified by the terms of reference.

1444. *Chairman*: I think the Working Party was an honest attempt, as you put it, to implement Spens.—*Dr. Wand*: Within the terms of reference. The Government insisted these points should be indicated in the terms of reference.

1445. It was an honest attempt in 1952 to implement Spens with these minor fringe amendments. From 1952 to 1958 there has been no means of knowing whether the honest attempt was a good or had shot.—*Dr. Stevenson*: That is so.

1446. You know we have issued a questionnaire to a sample of the profession, to find out what they are actually earning. It is an attempt to find out whether you hit the target.—We hope it will be effective.—*Dr. Macrae*: If the cutting of the cake has not been effected with mathematical precision, I should

have thought that no argument existed for reducing the size of the cake.—*Dr. Wand*: Not bringing the cake up to its proper size. You cannot cut the cake into a number of pieces as indicated unless the cake is of a size that will take that amount of cutting.—*Mr. Cooke*: One thing certain is that the Spens recommendations cannot be carried out unless adequate money is provided for the purpose.

1447. *Sir David Hughes Parry*: Can we turn completely over now to the question of the central pool? Can I draw your attention to paragraphs 74, 77 and 86 of your preliminary memorandum. Now you have sentences there the meaning of which is not quite clear. Paragraph 74 says:

"All the arguments so far adduced merely show the extent to which the profession's relative position in society has fallen short of the standards applicable in 1948 and ignore any changes which have taken place in the economic position of the community as a whole".

—*Dr. Wand*: I think this would be very much more effectively dealt with by an expert in this field, if you do not mind.

1448. He will have an opportunity. Then at paragraph 77, the third sentence:

"The medical profession has a right to expect a share of this increase, not only from the point of view of their relative standards of living as members of the community, but also because they have made their contribution to the increased productivity responsible for the rising national income".

Then in paragraph 86:

"... the Council submits that the medical profession has every right to participate in the benefits which are now enjoyed by other sections of the community".

I put it in the first instance that you are enjoying all the amenities that we are enjoying as regards all sorts of things that are dispensed to us by the Welfare State, but you want to have a guarantee in addition to that?—No. I think Professor Allen will explain this situation.

1449. Professor Allen, can I put it in this form? Is this a claim being made for a benefit having regard to the raising

of the standard of living of the community as a whole, or is it only in reference to professions or to the value of money?—*Professor Allen*: These are I think subsidiary to the claim as it has been formulated. It was based upon the fall in the value of money. Then the argument goes that so far the basis of the claim is concentrated on the fall in the value of money, which simply leaves the standard where it was at the beginning in 1948 or 1951. It draws attention to the fact that since that time the total output of the country and hence the standard of living of the whole community has in fact gone up. It is not the increase in the welfare service but the increase in the total amount available to improve the standard of living of the whole community which is in question. The figures in paragraph 76 show that the output per head, hence the standard of living of the whole community per head, in 1956 was 20.6 per cent. higher than it was in 1948, so that the cake to be cut up nationally—not the central pool—was so much bigger. The implication then is even if the doctor's remuneration is adjusted to take account of the fall in the value of money, it is still only at the level of 100 and is not participating at all in the 20.6 per cent. rise in the general standard of living due to the general increase in production. That is the point.

1450. There is no claim in respect of that extra? That is not turned into money at all?—Not in this particular claim, no.

1451. *Professor Jewkes*: This is an important conclusion and I think we all ought to be quite sure what is being meant. I am referring, *Dr. Wand*, to paragraphs 61 to 91 of your memorandum which we call the remuneration claim. It seems to me that you there really mention three criteria and I would just like to talk about each one of those in turn for a moment. The first criterion of course is that the cost of living has increased since 1950 to 1951 by 29 per cent., and that therefore, in order to leave the purchasing power of doctors' earnings unchanged, it would be necessary to increase doctors' earnings by 29 per cent.?—*Dr. Wand*: That is so.

1452. That is straightforward and clear, as mentioned by Mr. Cooke. Then we come to paragraphs 74 to 77. There Professor Allen has set down figures

which show that the standard of living of the community has been rising. In fact it has risen by 20.6 per cent. per capita between 1949 and 1956. The standard of living of the community has been rising, but what the medical profession is asking for is simply that your proper place in the 1950 standard of living should be preserved.—Yes. We are pointing out here that were we going for something other than the recognition of Spens at the present moment, we should be justified in adding to our 29 per cent., but we are not doing so. We are just bringing the fact to the notice of the Royal Commission.

1453. Yes. The medical profession you claim has a right to expect a share of this increase but in fact you are not making that claim.—That is so.

1454. In fact if you were in the process of making that claim the 29 per cent. would have to be something higher?—Yes. We are in fact saying that.

1455. Let us now turn to the third criterion. This will involve some matters of technical detail. The third criterion you have mentioned really is that doctors' earnings should rise roughly *pari passu* with the earnings in other professions, at least not less than those.—May I just modify that? Not less than such increase as has taken place above the changed value of money increases.

1456. *Chairman*: Yes, I think we have got the point.—I do not want to be misinterpreted.

1457. *Professor Jewkes*: Now there is the question as to whether the earnings of general practitioners have been rising as rapidly as, or more rapidly than, earnings in other professions. I would like you to deal with Appendix VII—the sub-appendix prepared by Professor Allen. I want you to turn to table 4. The crucial figure for our present purposes there is this line of statistics which shows professional earnings. Those earnings are the total earnings of the professions; they are not earnings per head. That is correct, is it not?—That is right.—*Professor Allen*: Yes.

1458. Professor Allen will know the next question I am going to ask. What relevance can we attach to statistics of the aggregate income of the earners of professional fees if we do not know their number? Is not the important thing

to know the earnings per head and compare them with the earnings per head of general practitioners?—Yes, Sir, I could not agree more. This particular line is limited in two ways. There is the line labelled "the aggregate annual earnings of professions". In the first place it is only the independent professions who are fee earners. It is not the new salaried professions, which are far more numerous. These are inextricably mixed up in the previous line, "salaries". Whereas we have an idea of the number of wage earners and salary earners, we have no idea of the number of independent fee earners. We have no idea and can only guess. For both those reasons I place very little weight upon the movement in these particular figures. It is a reed on which we cannot rely. My own view is that the number of independent fee earning professional people has gone down. And I would here make another point that the independent fee earners are very often part-timers; for sometimes nine-tenths of their time they may be salary earners. Equivalent full-time independent fee earners have gone down since 1948 partly because of the entry into salaried jobs of people who previously earned fees, like the consultant. That is only a guess. We have no information at all. All I can say is this information is not of very much guidance, which is one reason why we have so little to offer you on the subject of the movement of earnings amongst professional people or independent professional people.

1459. *Mr. Gunlake*: May I ask you to look at page 5 of your Appendix II? That appendix contains a reprint of the case which was submitted on behalf of the B.M.A. before Mr. Justice Danckwerts, and in paragraph 26 you will see the words: "It is possible to determine with reasonable accuracy..." And then there is a statement of four statistical indices. Would you look at (b): "The general level of net professional incomes per head." Not only is it there stated that it is possible to determine with reasonable accuracy a change in the general level of net professional incomes per head, but of all those statistical indices that was the one that was picked out in the following paragraph as the basis of the submission made to Mr. Justice Danckwerts. Yet you now tell us that nobody has any idea how

many persons there are in this category and therefore it is not possible to determine the level of incomes per head.—I would say on that, that during the hearings before Mr. Justice Danckwerts this particular point was much pursued, and the only way in which it was possible to determine with reasonable accuracy the changes in the independent national earnings per head, as compared with before the war, was to ask the Inland Revenue to produce figures which were otherwise not available. They did so, and those were among the figures that Mr. Justice Danckwerts took into account in making his decision. Those figures were produced in camera and are still not published figures.

1460. *Professor Jewkes*: They are still not published, but in fact they were blurted out in the course of the proceedings and were printed in the B.M.J. in 1952. On the points Mr. Gunlake has raised, your Appendix says: "It is possible to determine with reasonable accuracy the general level of net professional incomes per head." It is true that the Inland Revenue provided certain figures; you yourself provided certain figures, did you not, Professor Allen? In fact was there not a conflict between their figures and your figures? What figures did you use to determine the general level of net professional incomes per head in the course of the Danckwerts adjudication?—First of all I made the same points about independent professional earnings that I have just made on the figures you quoted first, that is not being able to do more than guess at the changes, or numbers even, between 1938 and 1950. It is possible to do something over a long period, because you have census figures. For short periods you are hopelessly at sea. But as between 1938 and 1951 you could do something, e.g. 1931 to 1951, so I did that something. So the comparison with pre-war is one thing, but the comparison year by year since the 1951 census is another.

1461. I see. I understand that perfectly.—Then I referred to the fact that the Inland Revenue had the data available. Then I passed on to a wider point—all earnings in the hierarchy coming down from the top can be determined at least once every five years by Inland Revenue data. That, again, I use in the present submission. This can be

done by using data which becomes available only once every five years and enables you to take all earnings together, however they are earned, from the top down and compare them. I then moved on to that position, having done as much as I could with the first position on the independent professional earnings per head.

1462. So really the position is you do not know year by year, and we do not know year by year, what the changes are in professional earnings per head. Do you not regard it as a misfortune that although the proper fixation of doctors' earnings calls for statistics of this kind they have in fact never been provided?—Yes, I do. In a much wider context I regard it as a misfortune too. My own personal view as a non-official statistician is that the failure of the Inland Revenue to publish more statistics is very damaging to our knowledge in this field.

1463. *Chairman*: Would you feel the enquiries we are making, not only from the doctors but from other professions, ought to produce in this particular field just the information we are wanting?—Yes. My difficulty is this. You can by special enquiries get information applying to a particular period; but that is quite a different thing from keeping that information up to date, bringing it up to date and keeping it up to date. You are always some years in arrears. I think Professor Jewkes's point is primarily directed to the need for current information, and I could not agree more. The data are there. They have only got to be analysed and published. We could get them perhaps no more than a year behind the times from the Inland Revenue, but the data are not published.

1464. The data that you had in 1952 from the Inland Revenue was sufficiently dissected as between self-employed and salaried people as well as between age groups, and so forth, was it?—The evidence that was produced there was for earnings of professions that were named—surveyors, engineers, and so on.

1465. Yes, but within the figures for the main professions did it mingle, for instance, salary and fee earners?—No, the information was produced for Schedule D, fee earning.—*Dr. Wand*: Sir Harry, I cannot speak as one having

any particular knowledge of this, but one of the difficulties was brought home to me from one of the papers I read last Sunday, in which it was indicated that the Institute of Chartered Accountants is ruled by a Council of 45 members, who hold between them 162 company directorships. I am not quite clear how it could be possible to find out in that sort of arrangement what were the earnings of fee-receiving professional people in other fields. It would seem to me to make it very difficult indeed, because the directorships associated with their work would result from that qualification. That was the purpose of the article, to show that they resulted from that qualification, but they would not be shown as part of their fee earnings in respect of their accountancy work. Yet it would be as a direct result of qualifying as chartered accountants.

Chairman: I think you may be wrong, but it is a point we could put when we see the Inland Revenue—as to whether a man's earned income excluded income earned from something outside his purely professional activities. But I would be surprised if you were right.

1466. *Professor Jewkes:* The deduction would be if we cannot get satisfactory figures of professional earnings per head, that we must give up all attempt to try and think of the proper association of doctors' earnings in terms of comparison with other professional earnings.—I think that Professor Allen can answer this very much better than I can in the field of economics, but in general terms I would say no. I would say, having determined, as Spens did, our place in the general hierarchy of the community, that place being determined by a relationship between the professions and commerce, industry, and so on, it could be reasonably estimated that there would not be such an enormous change in the position of the professions from year to year. And if you could determine a similar place in the hierarchy having regard to the known incomes of the whole community you could place the doctor there without needing to know the per head income of each individual member of every profession: you could assume there was some sort of relationship that would be continuous enough to be ignored if there was any marked change in the general standard. I think that perhaps with that general observa-

tion I might ask Professor Allen to deal with this. It does actually form the subject on one of the points that he has taken up in the Appendix.—*Professor Allen:* I wonder if I may go back a little and formulate my reaction to the two legs of the Spens statement about bringing up to date their 1939 figures—the two legs being the change in the value of money and increases in earnings in the professions generally. The first leg can be tackled by means of a figure on which agreement can easily be got—the decline in the value of money. By and large you can produce a figure and you can produce it year by year, indeed month by month, to show the decline in the value of money.

1467. *Chairman:* That is at the moment your 29 per cent.—Yes.

1468. And that is the protection against inflation?—Yes. My contention is that, though there may be minor disagreements affecting the decimal point, broadly that can be agreed. The difficulty comes in trying to put measures to the other criterion, the increases in the remuneration of the professions. In answer to Professor Jewkes, I have gone over some of the difficulties, using only published data, trying to get a figure for the professions as a whole. I have also made the point that the Inland Revenue do have data which would help, but are not published. Therefore, looking at this problem of making a claim it can be argued, as it was argued yesterday, that you take whichever is the higher of the two criteria, either the decline in the value of money or the increase in the other professions. Or you can do what a statistician often does, play for safety and go to the other extreme and take whichever is the lower. Then you stand pat on that and point to the other one as a further addition. In this particular case we have one measure, 29 per cent. We can take that as one of the legs. What we try to show in addition is that, though all professions—increases in the incomes in other professions, salaried or fee-earning—such information as we have is that the increases on the second criterion—other professions—are bigger than the fall in the value of money of 29 per cent. And though none of the facts are conclusive we point to changes that have taken place in the incomes of higher civil servants and of

teachers, amongst others, to indicate that at least in those professions changes since 1951 have been more than the 29 per cent. of the decrease of the value of money. Therefore the position I was trying to take was that we know one thing, the 29 per cent. This takes no account of the other leg, but if we could have full information on the other leg it is likely that the increase on that account will be greater, and we produce a certain amount of evidence that points in this direction.

1469. You say the increases in, for instance, the higher civil servants. Since 1951, Danckwerts has given 100 per cent. on the general practitioners' remuneration. Might it be that within the different professions there is a little bit of time lag and that the choice of a particular date might have a considerable bearing?—Yes, I was wanting to make a point here, even more generally perhaps than you have put it. There is always a difficulty in making comparisons and it is concerned with the choice of dates. Even when you are making the comparison on the decline in the value of money it does matter which date you start from—whether you start from April, 1951, or September, 1949, or May, 1952—because the movements are up and down around a trend line, sometimes faster, sometimes slower. So comparisons are always dangerous from one particular date to another. The advantage you have with the measure of the value of money is that you can see it month by month and can guard against bad comparisons—for example, taking the high points of one cycle with the low points of another. I think the measure of the comparison between April, 1951, and the present, in the decline of value of money is a reasonable one. When we come to the other criterion of Spens we are in much more serious difficulty. The value of money is changing all the time. The remuneration of any particular profession or broad group of professions is going to change discontinuously in the form of steps. You will see the diagrams I have given in Charts V and VI of the sub-appendix to Appendix VII. Movements in particular incomes are by steps; therefore it is very easy to get two quite different figures by varying the period of comparison by a month or two. For

example, if a change took place in October, 1950, as it did in the higher Civil Service and you make comparison with November, 1950, you get a small increase; if you do it with September, 1950, you get a big increase. In addition to that at no time can you say that one profession's income or salary is in line with others. They are advancing at different times and are always more or less out of step, and that to my mind makes it extremely difficult to apply Spens's second criterion at all. If you look at individual professions you have to take so much into account as to exactly when changes are taking place and for what reason. So I did no more than to point out what is obviously true, that between October, 1950, and the present the salary of a Permanent Secretary, Deputy Secretary and Under Secretary changed by so much. I did not try to say that was right or appropriate or in line with other professions. That is something which is difficult and quite different.

1470. In fact if there was a starting date for that second leg of Spens it was 1939?—Yes, and that date is so far in the past now. And you are not even certain they were in line with 1939.

Chairman: But that is the only date mentioned.

1471. *Mr. Gunlake:* Professor Allen mentioned a number of difficulties that there are in getting any idea of net professional incomes per head. I still do not understand why in the case submitted to Mr. Danckwerts it was stated it was possible to determine this figure with reasonable accuracy; and, secondly, why, out of the four statistical indices there mentioned, that particular one, which you have explained is the most unreliable one of the lot, was in fact selected as the basis of the submissions made to Mr. Justice Danckwerts, with no warning, as far as I can see in the text, of the possible inaccuracy of the figure. That is in paragraph 26 of Appendix II.—This document is without the very large statistical appendix which was attached at the time.

1472. I see.—It was an enormous statistical exercise, and this was the legal presentation by Counsel to Judge.—*Mr. Cooke:* That is so.—*Professor Allen:* It is not as I would put it myself,

it is in a different context. The statistical appendix which was taken as expert evidence in this connection was on quite different lines. I am sorry you are looking at one without the other.

1473. *Professor Jewkes*: I am just trying to get absolutely clear how much reliance we can place, given the absence of comprehensive statistics, upon this comparison of earnings of doctors with earnings in other professions. Could we turn to table 4 of your sub-appendix again. Professor Allen?—If you look at professions, index number 1950=100. Then the professions show an increase from 100 to 119. Now, if in fact the earnings of general practitioners were increased by 29 per cent., which is the present claim, would this not mean that the earnings of general practitioners would be out-stripping the earnings of other professions: or is there some explanation there?—It is partly an extension of the time. If you take 1951 to 1955, which is all that table 4 does, the movement is from 98.7 to 118.8. If you exclude general practitioners, whose incomes were constant in that time, it is from 97.3 to 121.3, which is about 24 per cent.

1474. Still not 29 per cent.?—The 29 per cent. is to October, 1957. Since 1955 the general level of prices, wages and earnings has gone up considerably. In fact there has been a period of more marked inflation than the years after 1952 shown here, and the change from 24 per cent. to 29 per cent. is the change from 1955 to 1957.

1475. If it were true, as you have suggested—and I think my opinion would be much the same as yours—that the actual number of people included in this professional group had been declining between 1951 and 1956, and if it were also true—we know this to be true, in fact—that the numbers of general practitioners have been increasing, the conclusion would be that the earnings of the professional groups had gone up by more than 29 per cent.?—Yes.

1476. In fact your 29 per cent. would then look a very reasonable claim?—That is my contention, yes.

1477. But in fact we do not know whether the number of heads in the group of professions has gone up or down?—No.

1478. *Chairman*: I mentioned the civil servants because you referred to them,

and also because that happens to be one particular group for which we have some figures, Professor Allen. You may not have these; I am not sure. But it is a fact that between 1939 and now the top civil servants have gone up by one hundred per cent., which is the same as Danckwerts. But of course since 1951, as you rightly point out, they have gone up much more than doctors went up under the 1957 interim award.—Yes.

1479. If you know those figures you may know that there are very few of the others who have gone up by more than one hundred per cent., except the Chief Medical Officer, who has gone up rather more. I do not know, Dr. Wand, whether you are implying that he is overpaid in comparison with the rest of the profession?—*Dr. Wand*: I have no comments at this stage, Sir—you are in the realm of economics.—*Mr. Cooke*: May I just say one thing on Mr. Gunlake's question? I do think it is very important in regard to paragraph 26 (b) of Appendix II that he should see the statistical appendix to which that paragraph was referring, because I think that when that has been seen he will probably see that the material presented was pretty solidly justified. It may not be very happily described in 26 (b), but I think the appendix itself is of very great importance. I think it is the thing that really matters on that aspect.—*Dr. Stevenson*: Would you wish to have the appendix?

1480. *Professor Jewkes*: Yes.—*Mr. Cooke*: I am sure that copies can be found.

1481. *Chairman*: We would be glad to have that, thank you, Dr. Stevenson. Are there any other points you want to make? As I have said before, we are hearing your views now on the interpretation of Spens, and particularly on the interpretation of this one paragraph of Spens to which you attach so much importance. Of course, as I explained yesterday at the beginning, the fact that we are questioning you on these things does not mean that we accept your view on them by any means, but at least you can try to convince us that that is the right view. Are there any other points on this main group of paragraphs?—*Dr. Wand*: I should have thought that the matters set out in the various documents we have submitted would have convinced you.

1482. *Professor Jewkes*: This is a matter on which if we could get agreement it would, I think, save us all a good deal of thought. I do not know how far you would agree with this—I will not go through the details to start off with because you may agree forthwith, in which case we can avoid the details. Would you agree, Doctor Wand, that the increase in the average earnings of a general practitioner between 1939 and the period after Danckwerts, 1950, was 136 per cent.? I will go through the details if you like.—*Professor Allen*: I am sure we can agree what it is. A good deal of misunderstanding has arisen on this point. It is between 135 per cent. and 140 per cent., made up as follows: the increase of the actual 1939 earnings to what Spens thought the earnings should be, which amounted to about 19 per cent.; and then the application of the Danckwerts one hundred per cent. to that.

1483. Yes.—*Dr. Wand*: I would make this point, of course. This figure has been used in other places—in my opinion in the wrong context. The 36 per cent. which is added to the 100 per cent. of Danckwerts and the figure you have given us represents the underpayment determined by the Spens Committee of the general practitioners in respect of their work under the old National Health Insurance at 1939, an underpayment which had been going on for many, many years before that, and was never made up. We never got the back payment which was inherent in the findings of the Spens Committee and which was indicated by the £3.1 million. As long as I have made that abundantly clear I do not think we need say any more about it.

Professor Jewkes: I think we are agreed on that figure.

1484. *Chairman*: Since Danckwerts has been mentioned there is just one question I want to ask before we go to lunch. There is a deduction made—or addition, whichever way you put it—for private earnings, earnings outside the National Health Service. I think it is always agreed that that should be as nearly as possible, the actual figure, but it is at the moment an arbitrary figure.—*Professor Allen*: Yes.—*Dr. Wand*: The figure determined by Mr. Justice Danckwerts.

1485. Yes, it was an assumed figure, I think, not a calculated figure, and that figure has remained unchanged.—Yes.

1486. It would be surprising if it is exactly what it is assumed to be.—It was the determination of Mr. Justice Danckwerts in the light of the information he received from both sides.

1487. *Chairman*: I do not think we really want to go into that at this moment. May I ask you this? You do say in paragraph 8 of your evidence that you are going to let us have a great many other supplementary memoranda in due course.—Yes.

1488. These will include more detailed evidence, for example, on junior hospital staff, senior hospital medical officers, teaching staff and so on. Can you give me any idea when this series of memoranda is likely to start coming through to us?—*Dr. Stevenson*: There is one memorandum on part (c) of your terms of reference which we are very anxious to have an opportunity of presenting, and, I hope, discussing with you. We would hope to have that in your hands by the 1st March. The other memorandum I think you will also have by March, certainly before April.

1489. There are just two, are there?—At the moment we want to let you have our thoughts on the review machinery of the future. But the other evidence, which will be mainly on the hospital field, will embrace all grades of hospital staff. There will also be a memorandum on the public health service. I think probably they will be in your hands by March, certainly by 1st April.—*Dr. Wand*: I am hoping you will have a lot of further evidence by 1st March or thereabouts.

Chairman: Thank you very much. I can assure you we are getting a great deal of evidence from many other bodies, but we would like to know when we are to get the B.M.A. evidence.

(The proceedings were adjourned for lunch)

On Resumption

Chairman: For a number of reasons, Dr. Wand, it will be convenient for the Commission to try and finish rather earlier than 4.30 today.

Sir David Hughes Parry: There are two or three matters on these figures to

be cleared up, and I thought that Professor Jewkes might clear up one straight away.

1490. *Professor Jewkes*: Mine is a small point, Dr. Wand. In the last four or five years the average size of list has been falling. The average net earnings of general practitioners has remained constant at £2,222; so that although the earnings of general practitioners have not increased you have had some advantage in the sense that you are earning the same amount of money, although the average size of list has declined.—Yes, that was envisaged in the Danckwerts award in which Mr. Justice Danckwerts did indicate that that principle should apply unless at any time—I will quote the precise words out of Appendix 3: "If the number of doctors in the Service became unreasonably large this point would require reconsideration." He did not say it would be altered at that point, but it would require consideration at that point. That was anticipated by Mr. Justice Danckwerts.

1491. *Chairman*: You do not consider that the number of doctors in the service is unreasonably large?—No.

1492. *Mr. Gunlake*: I have some matters to raise of a rather general nature. Dr. Wand, you will recall that just prior to the luncheon interval yesterday it was made clear by you in answer to a question by Professor Jewkes, and indeed it has been reiterated in this morning's proceedings, that it is your contention that the remuneration of the medical profession should be adjusted upwards in accordance with the decline in the value of the pound sterling, or in accordance with the increase in the remuneration of other professions, if that should be larger. I would like to ask you in the first instance whether it is your view that that method of adjusting remuneration should be applied to other citizens as well as to doctors.—We are only concerned here with the remuneration of doctors, and I do not think that I could properly answer a question which is based on so many other factors without giving it very much more thought than just giving you an answer off the cuff.

1493. *Chairman*: And that applies to both those two criteria, does it, the inflation and the changes in other professions and occupations?—Well, Mr. Gunlake, if I may say so, has omitted one of the

essential premises that apply to a question like that. If he had put the question to me in this way, that are there any special circumstances which make it necessary for you to have your remuneration adjusted in this way, my answer would have been an unqualified yes. But the question was not that; it was—what is the situation in regard to the rest of the community. I can only say that we as doctors came into the National Health Service under certain conditions, of which acceptance by the Government of the Spens Report was probably as important as any other. My answer to such a question can only be that here was a promise given by the Government. It is true that Governments change, and Ministers change with even more amazing rapidity, but even so the profession came in on this basis and therefore it is on this basis that remuneration has to be adjusted. This matter should surely have been considered by those who made these promises before they made the promises.

1494. We were just asking your view.—Yes, Sir. You see, on the question itself I do not feel competent to reply.

—*Dr. Stevenson*: Could I make one point on this? Although the question is applied to the whole of the community, in so far as professions are concerned, medicine is now in the position of being practically entirely dependent on State funds. There is no other way in which these funds can be adjusted, as those of many sections of the community can be.

1495. *Mr. Gunlake*: They could not be adjusted by the usual process of negotiation?—I think if you read this document you will see what has happened.

1496. I understand your answer in effect to be this: that whatever might be right or wrong for the rest of the community, you do claim this particular method of adjustment on behalf of the medical profession?—*Dr. Wand*: The claim has been made on our behalf and accepted by the Government. The claim was made by Spens and accepted by the Government. And we look on that as part of our contract with the Government, an obligation on the Government. Indeed, I would go further and say that in the past it has been an obligation for the Government to come to us without our having to make a claim in order to implement it.

1497. I think I have that clear. You claim this as an automatic right on the basis of the circumstances in which you agreed to enter the health service?—That is right.

1498. And you allege that it is an agreement made with the Government. What you mean is that it is an arrangement made with governments for ever, that the government of the time in entering into this arrangement with you committed its successors in perpetuity?—Not in perpetuity. Mr. Justice Danckwerts has indicated one way in which circumstances could change. We say that in 1948 we were in the service on one particular obligation. It was brought up to date in 1952 by a judgment of Mr. Justice Danckwerts, who determined that the only change that he could foresee in this contract, as I will call it, was that the number of doctors might become unreasonably large.

1499. *Chairman*: I think, Dr. Wand, Mr. Justice Danckwerts' qualification related to the fact that he had adjusted remuneration by reference to the number of doctors and not of the population. He was still trying to interpret the Spens figures of the distribution of income as between doctors. He had taken that measure.—I was taking the question to be one in more general terms than that.

1500. Yes, you are right.—I was taking the question in general terms and in its general impact, and I tried to answer in its general impact. The only comment that Mr. Justice Danckwerts made about its general impact was in relation to the number of doctors, and there he said that if there was an unreasonably large increase further consideration would be necessary. Of course, I have been answering these questions in general terms. I could go into more detail. For example, the number of doctors has got to increase because the population has increased, and so on.

1501. We have not spent much time on Mr Justice Danckwerts' award, and I do not think there is any particular reason to do so. I think it is fairly clear. But one of the changes of method that he made compared with Spens, for purposes of convenience and with no other significance, was to interpret in terms of the number of doctors rather than in terms of the population; is that not right?—I would not say for reasons

of convenience—for reasons of justice, equity. I do not mind which of the words you use, but I mean them all to have the same context more or less.

1502. Thank you for that. I am not quite clear that I know where that comes from. I understood that he was in fact trying to interpret the change in the value of money and that he did it, and he says there: "by reference to the number of doctors in the National Health Service, and not the population."—I say he went further than that in that particular field.

1503. *Mr. Gunlake*: I would just ask one further question. I think it is fair in the circumstances. Do you consider, Dr. Wand, that if a government enters into an agreement such as you contend was entered into here, it is not an unconscionable arrangement from the point of view of the economy?—In 1950 we received a letter, which is quoted in paragraph 16 of our memorandum: "The Minister agrees that the Spens Report remains the basis of the remuneration of general medical practitioners until such time as after the usual consultations some other basis is substituted." If the purpose of the question is to say should we have a day to day adjustment in terms of that, my answer would be no, it was never so intended. But in general terms, this sort of thing must go on if the obligation contained in the acceptance of the Spens Report is continued until such time as the promise of the Permanent Secretary that I have just read out to you is dealt with.

1504. *Mr. Watson*: Would that be irrespective of any internal factors—of trade or further inflation or governmental difficulties?—This is again a matter of economics which may be considered to be outside, and probably is outside, my sphere, but I would say this: that if we are tied up with the diminished value of money and we find that the rest of the community has been able to make arrangements to deal with this changed value of money, it is a reasonable thing for doctors to say that, having waited for five years (nearly six years now—it is over six years now since we had an adjustment) we have carried out all that the rest of the country, having regard to the economy, could have expected of us—indeed, a lot more. It is our sense of responsibility which will enable us to have regard for that, and this long delay

is an indication of our sense of responsibility.

1505. *Chairman*: That is not quite a reply to Mr. Watson's question, Dr. Wand.—I think, Sir, with respect, I have got the idea behind the question. I am trying to reply to that. I see the purpose of the question, I think. I think I can say that we have delayed, that the remainder of the community has indeed got in front of us. And it is partly because they have got so far in front of us that we have found it necessary to make this claim. Should that situation arise again—and this is my point—it would have to be done again if the rest of the country had been able to huffer itself against the changed value in money. Have I answered your question, Mr. Watson?

1506. *Mr. Watson*: You have not, Dr. Wand, really.—Could I have it in another form then?

1507. In the event of the country being faced with economic difficulties, in the event of the Government being faced with grave economic problems, is it the contention of the B.M.A. that irrespective of those factors the promises made or the awards given should automatically apply to the members of the profession?—If others have been insulated in that fashion, and if we have waited an adequate time, then I think the answer must still be yes. If others have insulated themselves, if we have given the economy a chance to reverse the trend, if that trend is not reversed we have got to come in on the original trend. Does that answer it?

1508. Yes.—And in this case we have waited six to seven years. There should be an automatic adjustment under those circumstances. When we come to provide you, Sir, with some suggestions on your terms of reference 3, I think you will find that we have had regard to that sort of principle, concerning the question of delay.

1509. *Chairman*: If I can follow that up, I am still not quite clear on your answer to Mr. Watson. Are there circumstances, national circumstances, in which you feel that an adjustment in the changed value in money would not be required?—Well, Sir, this is an absolute question; it is a question which can mean "for all time". But if you take it as meaning "at any given time"

I think I have answered it. I have answered it in this sense, that we must have an automatic adjustment, but being reasonable people we will wait to see if adjustments that have taken place in other fields require compensatory adjustments in medicine. We do in fact wait because we are always behind due to the delay in getting statistical evidence, for example. We have waited to see what would happen in the economy, and the time has come when we are compelled to say: "The time has come when we have got to be considered". We have delayed a considerable time. But I am not asking for day to day adjustments such as do occur in some industries. Dr. Stevenson has just pointed out to me that in the case of war there would be a very, very different set of circumstances. We may then be in the middle of a claim. We were, indeed, in the middle of a claim when the last war broke out.

1510. *Mr. Bonham-Carter*: Dr. Wand, it is—if I understood Mr. Cooke this morning quite correctly—an important part of your case that the words "should have direct regard . . . to estimates of the change in the value of money" are interpreted to mean that the adjustment should be 100 per cent. of the change of the value of money.—Obviously, once an adjustment is made it should be the proper adjustment. The adjustment, being very, very late, and in view of the delay in obtaining figures, is of itself a reduction in an inflationary trend.

Chairman: Thank you. That is what we wanted to know.

1511. *Mrs. Baxter*: Might I ask this? We have heard, Dr. Wand, about the doctor/patient relationship, which of course is a matter of great interest, particularly to lay members of the community. Is it the view of the Association that this relationship would be improved or affected in any way by the knowledge that the doctor alone of the professions had the certainty that, whatever happened to the other professions, his position with regard to remuneration is cushioned against inflation? Do you think that this would improve the relationship between doctor and patient?—I am perfectly certain that if doctors felt and knew that the promises of the Government, which by Act of Parliament has taken on the responsibility for the whole

medical services of the country, if they knew that the Government were going to implement their promises adequately it would create a feeling of satisfaction with the persons with whom they were in contact, which is bound to improve all relationships. Under any circumstances we try to ensure the best possible relationship between the patient and the doctor. Yet in the Spens Report it was indicated quite clearly that doctors should not have their work hampered.

1512. *Spens* refers to the anxiety of doctors, does it not?—We have no doubt that low incomes have in fact been a source of grave worry to many general practitioners and must have prejudiced their efficiency. That is what the Spens Committee thought, and I think that would be part answer to your question. But, if I may say so, I do not think that this is a cushioning as compared with other professions. Other professions are in a different position. The doctor can only practise medicine. Members of other professions have other walks of life to which they can go, and in fact do go. Other professions, many of them, are fee earning; the professional man is his own master, or can easily become his own master.

1513. *Chairman*: I think Mrs. Baxter has got the answer to her question. You mentioned before about the Government honouring their promises, as though they had broken them. I want to make that quite clear. This is just your view, is it not? It is not of course admitted by the Government. Is that right?—But throughout the document which is before you it is indicated over and over again that the Government have said: "We accept this" and "We accept that".

1514. Yes, but, Dr. Wand, is it your interpretation that the Spens document has not been honoured?—*Dr. Stevenson*: There is no doubt that the Government accepted Spens.

1515. That is the point I am trying to make.—*Dr. Wand*: They accepted the Danckwerts award as well.

Chairman: That is the point. You are maintaining that the Government have broken their promises. We have no reason to believe that the Government say that, nor have you any reason to believe that we necessarily share your interpretation of Spens and its consequences.

1516. *Mr. Gunlake*: Dr. Wand, I think we fully take your point about your forbearance in waiting all these years before making any claim in the face of inflation which successive Governments have wickedly allowed to continue. You did refer to other members of the community maintaining their position in the face of that continuing inflation. I am wondering if you have any evidence you can lay before us as to the extent to which people remunerated at, say, the £2,000 a year level, have maintained their incomes in relation to what you are now using as the basis of your claim, namely the index number of market prices for all consumers.—I think Professor Allen would be the appropriate person to answer that.—*Professor Allen*: There is not much evidence at this level. The supplement to Appendix 7 gives civil servants' and teachers' salaries, but among civil servants when you get to the higher levels the changes occur less frequently and there is a longer wait. Teachers' salaries just about get to the £2,000 level, but no more. The only other piece of evidence I have got is rather out of date. It may be indicative. It is in Appendix 9, where I use Inland Revenue data that becomes available once every five years, and show a period from 1949–1950 to 1954–1955—Table I and the figure that goes with it. Around the £2,000 level the increase in earned income, taking all earned incomes, however they are earned, was of the order of 16 per cent. in those five years. At a slightly lower figure it was nearer 17 per cent. and at a slightly higher figure it is 15 per cent. But around £2,000 or £2,500 it can be said with this evidence to have been 15 or 16 per cent. over a period of five years. That takes us to 1954–1955. This kind of information which it is very useful to have is unfortunately only made available once every five years. This information became available to us and was published in the Inland Revenue report last January, just a year ago, and related to the years 1954–1955.

1517. *Chairman*: I think we realise your difficulty, Professor Allen, and we are trying of course in a number of ways to get accurate information ourselves that may assist in that way. I would, by the way, like to say, Dr. Wand, that the total amount of information, and the Appendices that you have provided for us inside these rather gloomy folders,

have been extremely useful. You have given us a great deal of information in a nice compact handy form. I do not know whether you had any particular reason for clothing it in black?—*Dr. Wand*: None at all, Sir; it is the sober truth, Sir.

1518. *Sir David Hughes Parry*: We would like now, in the short time that there is available, to consider the Spens Report on Consultants. The terms of reference are very much like those for the general practitioner report—practically on the same lines.—Yes.

1519. Can we move straight away to the summary of recommendations and conclusions because those are the things that contain the gist of the Report. May I take No. (1) and ask how far that has been implemented if it has been implemented at all?—On this we are on very different ground from the general practitioners, and Mr. Holmes Sellors will show you how in some of these cases, where the general practitioner has in our opinion been treated unjustly over the last few years and advantage has been taken of our professional obligations, these factors are even more blatant in the case of consultants on hospital staffs. I think Mr. Holmes Sellors will enlarge on that.

1520. I think it would be convenient to us to take the recommendations one by one, and then we could have a general run afterwards.—*Mr. Holmes Sellors*: Yes, Sir, with the knowledge that there have been a number of adjustments within this scale since the Spens Report—I mean alteration in grades, other grades introduced, and so on.

1521. The general answer is that No. (1) has been implemented, is that right?—It has been implemented, but after the Spens Report, of course, we did have the two appointments in the post-registration phase before qualifying and they come as one heading in the Report.

1522. Has there been betterment added to these figures?—May I go a little through the history because it is a rather complicated story. As you are all aware when the Act came in 1948 this Report had barely been published, and there had been no chance of discussion on the Report and its contents between the Ministry and ourselves. There was therefore about a year's interim period where the hospital staff worked on interim contracts at a very much lower

rate than what they hoped the final figures would be. Leading on from that were the negotiations to decide if any betterment was to be allowed taking the basis of the value of money in 1939. The consultant side suggested that some figure in the region of 85 per cent. should be looked at. As time was getting on—we were in 1949 and 1950 by then—this was not so very far from what the Danckwerts Award gave the general practitioners. But the outcome was that at the end of one year the Ministry, as you will see in our main document of evidence in paragraph 52, issued not quite an ultimatum but something that might almost be regarded as that. They said if you go on postponing entering into contracts it is an aspect we shall be bound sooner or later to review. And the impression that was given was that it might well be reviewed adversely. The figure—I will not say agreed—allowed to us was 10 per cent. at the maximum end of the scale in 1948 and 13.3 per cent. at the minimum plus an employers' superannuation contribution as well. At very best that could not be counted as more than a 20 per cent. betterment. That figure was not accepted by the profession, who said that when proper negotiating machinery had been established they would like to raise that again.

1523. But these figures were accepted at what time?—1949. In 1949, after we had had one year on interim contracts at lower salaries, and after there had been this virtual revolution in the whole hospital world under which the State became the virtual monopolistic controller of all hospital beds—with very few exceptions. The only form of employment that a consulting surgeon or physician could apply himself to in properly equipped hospitals was in charge of the State. The next point was during this time when we were trying to establish negotiating machinery, and as you know that came within the realm of the Whitley machine—we had dealings with the Management Side of Whitley Committee B—the Danckwerts adjudication was under way. It was made quite clear then that we would certainly re-open our case. As soon as the award was known there was an announcement in the House of Commons by the Chancellor of the Exchequer and, as a result of that, the then Minister of Health—I do not know if he was the third or the fourth we have

had in the Service—summoned the Joint Committee to him and told us in no uncertain terms that as far as other branches of the profession were concerned the Danckwerts principle had no application. In other words there was no question of our being allowed to go to arbitration or, as far as we could make out, to take part in any form of negotiation as a result of that award on any back claim that we felt had been accumulating since our entry into the Service. That was opposed very vigorously and finally it was agreed, in the celebrated phrase that is used—"on the merits of the case"—that the disparity of balance the Danckwerts Award had now caused between the general practitioner and the hospital service remuneration was detrimental to recruitment to the hospital service. That was not negotiated until the very, very last stages. What happened we do not know, but after an interval of the best part of two years to my recollection, we were faced with a sum of money that was to be offered to consultants very much on a take it or leave it principle. There was no negotiation about that figure; it was presented to us as a figure we could take or not as we wished. It has been impossible to interpret this sum into any terms of betterment because conditions applied to it at the same time meant that a certain number of consultants with the higher merit awards were actually offered a reduction in their rates of remuneration. They also lost the weighting to which considerable importance had been attached. Those factors were still more adversely affected in the 1957 5 per cent. adjustment, because that reduction has worked even still more adversely to those people's salaries. So if one puts it in short our whole process of negotiation on the major problem of remuneration has been, I think I might almost say, fruitless since the beginning of the Service. Negotiation in the sense that we would understand it has hardly ever taken place.

1524. And the total betterment figures, therefore, were 16 per cent. in the first instance and somewhere near 30 per cent. in the second?—No, I do not think we would calculate anything as high as that. In 1954 we would say 12 per cent. at the maximum and 20 something at the minimum.—*Dr. Macrae*: I have some exact figures here that might

interest the Commission—figures for the consultant on the basic scale and figures for the senior registrar. Taking the consultant on the basic scale first: what he got at the minimum of the scale when the terms of service were agreed in 1949 was Spens plus 19 per cent., 19 per cent. higher than Spens—that is the figure for 1949. In the case of the senior registrar it was Spens plus 17 per cent. That is the gross betterment figure taking into account, of course, the Government's 8 per cent. superannuation contribution.

1525. *Chairman*: Are these broadly the figures in Appendix B of the Ministry's factual memorandum?—I do not know, Sir, they are figures I worked out for myself.

1526. Probably the same figures except that yours are in terms of percentages. However, continue to give them.—At the time of the 1954 adjustment the consultant at the maximum of the basic scale got an increase of 12·7 per cent. which brought his betterment up to the figure of 34. What he got in 1954 at the maximum of the basic scale was Spens plus 34. What the senior registrar got in 1954 was an addition of only 7·7 per cent. on his existing salary, again at the maximum, which brought him up to a betterment figure of 26 per cent. So the consultant at the maximum went up to Spens plus 34; the senior registrar at his maximum went up to Spens plus 26 at the time of the 1954 adjustment.

1527. Could you perhaps give me two other figures? One is what the consultant on the top merit award got—obviously a much lower percentage—and the other is the figure at the bottom of the scale, the junior house officer.—The figures I have here, which are some I worked out in April, 1954, show that the consultant with the top merit award got a betterment at the old 1949 scale of 13 per cent., and as a result of the adjustment in 1954 he went up to 15 per cent. at the minimum and 14 per cent. at the maximum. The house officer got in 1949 20 per cent. over Spens, and as a result of the 1954 adjustment went up to 46 per cent. over Spens at the minimum, 40 per cent. at the maximum. But he did not actually get as much as that because there was an addition to the sum he had to pay in respect of residential emoluments. But the actual salary figures showed that the

degree of betterment was 46 over Spens at the minimum and 40 at the maximum.

1528. *Sir David Hughes Parry*: Therefore, if the same considerations were to apply to both Spens reports the betterment should have been 136 per cent. which is the figure we agreed on earlier for general practitioners. —*Chairman*: No, 100—at the moment 105. —*Dr. Stevenson*: That is right.

1529. *Sir David Hughes Parry*: And there has been no implementation in that way? —*Mr. Holmes Sellors*: And even one other factor, Sir—there has never been any betterment to the merit awards at all.

1530. *Sir David Hughes Parry*: No betterment at all. Now we have got that, I think. Now would you like to make any comment as to the implementation of Spens recommendations (2), (a), (b) and (c)?—I think the same applies to all. All these scales have followed the lines of whatever adjustments have been made with the exception of the top consultant with an A or B award who has actually been abated in the 1954 award by £200 and £300.

1531. Is there any other matter than the betterment in which there has been no implementation?—There has been no question of any implementation on such subjects as domiciliary consultations which were originally part of the Act, and the schedules of fees for private patients and so on. The figures are as they were originally negotiated.

1532. No increase at all?—No increase. Of course we have had a great deal of difficulty on the question of expense allowances—for expenses of both part-time and whole-time officers.

1533. *Chairman*: Perhaps it does not arise just on that, but did the consultants at the top ask for a betterment of any kind in the 1954 negotiations, or did they consider that the merit awards . . . —*Sir*, there were no 1954 negotiations. There was a sum of money presented and I think the mechanism by which it was regularised was by correspondence with the Management Side of the Whitley machine. The negotiation got as far as—I suppose in those days—a 2½d. stamp.

1534. Thank you. Now I think we have heard that it was considered at the time that the disparity between the two different branches of the pro-

fession was pretty well redressed by those negotiations?—As far as we could judge, Sir. There was clearly some point, when we had made no progress in any negotiation ourselves, to decide what we considered on both sides of the profession would be approximately equitable. There was nothing that could be calculated in figures—I have nothing to say about figures at all. We assumed, as reasonable people, the attitude that the 1954 agreement certainly redressed any unevenness that had existed in the salary scale.

1535. One is bound to conclude that Danckwerts, just applied to the general practitioner side, certainly produced a disparity in the view of the profession. —I think that was fully thought and agreed at that time.

1536. I think one is also bound to conclude from those figures that before Danckwerts there was a disparity in the other way.—The disparity was assumed to be to the disadvantage of the general practitioner at the start of the Service and, after Danckwerts, to the disadvantage of the consultant.

1537. The assumption is that the two Spens Reports taken together produced a disparity in favour of the hospital service. Is that right?—It was our delay of a year in negotiating. We had accepted Spens in 1948 as a basis to work on and agreed to start the Service on the terms and undertakings we had understood the Government to give. We did not negotiate any betterment terms until the best part of a year later.

1538. I can understand that there is no parity near the top of the profession when you are well established in the one branch or the other, but near the bottom of the profession—in the earlier ages I mean—was it thought right that the house officer should only get 46 per cent. betterment, I think Dr. Macrae said, compared to 105 per cent. for the younger people in general practice? Was the disparity adjusted at that end as well as elsewhere?—I think one must remember that at the start to either branch of the service you must come through the hospital service in the first year or two years. People are working in hospitals before they have decided on their careers, and the terms negotiated for the house officer on those scales were on the figures that were given and have now

been implemented. And it is not until you get beyond that stage where the junction takes place that any comparison could or should have been made, because it is common ground for the two up to that point.

1539. Yes. My point really was that once he has passed the junction, the general practitioner is getting 105 per cent. on what Spens said, and before he gets to the junction he is only getting a maximum of 46 per cent. on what Spens said. There is presumably a much bigger jump at that stage than was ever contemplated?—*Dr. Wand*: There is this point. There was no worked-out relativity as between the different parts of the profession in the early days of the Act. There seems to be an idea that perhaps there might have been some very definite relativity worked out. That was not so. There was imposed on the consultants a betterment with which they disagreed, and once that had been imposed there was a certain relativity between the consultants and the general practitioners. In other words once the general practitioners were on their particular remuneration and the consultants had accepted their contracts under the betterment factor with which they disagreed, that produced a certain relativity and it was that artificial relativity that had been broken by the Danckwerts award.

1540. It is right to say that medical practitioners in training during their tenure of the hospital posts would receive in the first job a fixed salary of £600 a year?—That is set out in Spens.

1541. Spens recommendation 1 (a).—*Professor Allen*: That is not the house officer.

1542. I am sorry, I was at cross purposes; you are quite right. The house officer actually started at £350 in 1948 which was presumably the equivalent of perhaps £250 or £300 in terms of the 1939 values as translated for the consultants?—*Dr. Wand*: Was it as much as that? I was referring to your previous remark about the bifurcation.

1543. *Sir David Hughes Parry*: You were referring to the senior house officer?—No, I was referring to the point that was made that up to a certain point we were all on common ground and after that point the two sections of the profession each went in its own direction. I was referring to the con-

sultants as against the general practitioners in terms of relativity, and I was trying to indicate that an artificial relativity had been provided by the Government's imposition of this too low betterment factor in the early contracts, that this artificial relativity had been broken by the Danckwerts award. I was trying to indicate that there was no deliberate relativity ever engineered as between the two groups.

1544. But you came to the conclusion yesterday that this artificial relativity was at the present time on the whole working reasonably well?—I said that the general practitioners were satisfied that if the proper amount was put into the global sum they were prepared to work out any changes that may be thrown up when information is available. But that there should be—if it was possible to find some method of implementing paragraph 14 of the General Practitioners Spens Report—some additional remuneration in certain circumstances. I then said that if that chasm could be bridged to some extent by that paragraph 14, then it would bring them into closer alignment, and that one also had to look at the overall picture of a man's professional life.

1545. I wonder if I could move just a little from there. You talked about the bifurcation at this particular point. We are very concerned, naturally, with the remuneration of those who immediately go into general practice. As I understand it they can go in one or two ways, generally speaking. They can go as assistants—and I think we are going to hear more about that in due course?—*Dr. Wand*: We have with us this afternoon Dr. Potter who can answer any questions on that.

1546. Another way is that they can put up their plate in particular areas, and a third way is that they can be taken into a partnership?—And the fourth way is they can get a vacancy.

1547. Perhaps we had better hear a little about the assistant.—Could I introduce Dr. Potter, who is the Medical Director of our Medical Advisory Bureau? Dr. Potter handles enquiries on this subject and he is at your mercy, Sir.

1548. Would you tell us generally about the procedure for advertisements for assistants; what sort of salary is offered; what sort of advice you give?

We want all the assistance we can get.
—*Dr. Potter*: I have no direct control over advertisements.

1549. Before you go any further at all, there is a possibility of control, is there not, by refusing to advertise?—That depends on the policy of the Association. I have no control over that.

1550. *Chairman*: But by the Association you mean the B.M.A.?—Yes. On the other hand I am Director of a Bureau which introduces assistants to principals, and I send out a number of circulars from time to time to those eligible for posts in which the salaries offered and conditions of service are stated. I looked up yesterday all the posts of that nature which I have circulated this year. There are some 16 of them and an average salary gross—I must speak in gross terms because of the value of such emoluments as rent-free furnished house and so on . . .

1551. You used the expression "this year". That means . . . ?—During this month. Actually the report that I have is that, assuming a rent and rate-free house, furnished or unfurnished, is worth £200 a year, and full board and lodging is worth £250 per annum, the average gross remuneration offered to assistants in these posts is £1,250. Turning to advertisements, I notice it is reported in "The Times" that out of 100 advertisements 14 offered salaries lower than £900. I have looked at the last two issues of the Journal which contain in all, 34 advertisements for assistants. In only nine of those are specific details given. In those nine there is no salary less than £1,000, and there are several which offer considerable additions. For instance there were these examples last week: £1,000 plus increments of £50 a year plus a rent and rate free house; an assistant for three months, £300—that is £1,200 a year all found; another assistant £1,200. These are all advertisements which have appeared in the last two weeks. Another one: an assistantship in Yorkshire—£1,000 plus free accommodation and all car expenses. That is the average level of all assistantships.

1552. *Professor Jewkes*: When you mention a case of £1,250 gross, would that mean the assistant in that case might have to meet certain expenses? He must, for example, if he ran a car and so on and so forth?—Yes, Sir, most gross

salaries include a basic salary plus a car allowance, plus certain residential emoluments. In a proportion of cases the car allowance is calculated to include the probable cost of petrol and oil. In a great many other cases a car allowance does not include that because the principal regards it as a practice expense.

1553. *Mr. Bonham-Carter*: May I just clear my mind as to the youngest candidates that could be considered for these vacancies. They would have qualified, say, at 23?—*Dr. Wand*: at 24½.

1554. They may, at the present moment, have done some National Service?—They usually do two hospital posts which entitles them to come on to the register. They then do their National Service—those who have not done it during their training.

1555. At 28 years old?—One finds, comparing with the conditions when Spens made his recommendations, a very much larger proportion of these assistants are several years older and a very much larger proportion are married.

1556. *Chairman*: I think it is clear in Spens that this figure of £500 was intended to be a net salary. I think any question of their having to provide a car and to drive was intended to be met by an extra payment?—Yes.

1557. £500 would now be, in terms of Spens plus interim adjustment, £1,050. That is one of the few things that is to some extent in the control of the profession in that if anybody offered less than £1,050 as an initial figure now to someone just qualified you could refuse the advertisement—if that were the policy of the Association.—*Dr. Potter*: It is not the policy of the Association, but of course it could be done. But one would have to be sure in the offer of a lower salary that there was not a rent free, rate free house in addition which would immediately hump up the value of the appointment.

1558. *Sir David Hughes Parry*: One would really have to fix on the figure of £1,050 as a purely net figure?—Yes. If I may give an example: a salary of £900, car allowance £200, and a rent and rate free furnished flat would, in the terms I have been quoting, come up to something like £1,350. Yet it would still be possible to claim that that was a salary of less than £1,000. If I may just offer another piece of information which

may help—I assume Spens made his recommendations on values of salaries paid to assistants, offered at that time. I have looked up this morning certain posts offered by the old British Medical Bureau. They advertised in the region of £400, together with certain additions such as car allowance, then in the region of £50. There is another point which I think is relevant to this. The salaries that I have quoted today are not yet conditioned to the £50 rise in the car allowance which has been given to trainees; that will follow naturally after a certain lag. Certain advertisements have now been accepted including that. There was one this morning of £1,200, but that allowance, the extra £50, has only been published to the profession for a fortnight and there has not been time for these car allowances to be adjusted.

1559. *Chairman*: Thank you very much. I think that gives us a starting point on that side of the bifurcation. Now the comparable post immediately after the fork. Mr. Holmes Sellors—that would normally be the medical practitioner in his hospital post described in Spens recommendation 1 (a). Would that have been comparable to the assistant, roughly speaking?—*Mr. Holmes Sellors*: Their first appointments, shall we say, after their registration are at a lower rate because as you see in the house officer case there is a deduction in respect of board and lodging off their salary which does make it on the very meagre side. It simply depends on the stage they gain on the promotion scale, through senior house officer to registrar and then the bigger and more important jump to senior registrar. The salary scale is mounting, but by that time a man is virtually committed to the hospital service. There will be exceptions, of course, but by and large he will be in training for consultant work. In every grade below that, until that time, he might opt into general practice or any other branch of the profession.

1560. The transfer can take place?—*At a number of points along that scale, but once he has reached the senior registrar, which we regard as the proper training grade, then he is committed more or less.*

1561. *Sir David Hughes Parry*: Could we turn to the man setting up his plate in a designated area? What happens in

that case?—*Dr. Davies*: A young man, to be accepted in a designated area—that is an open area—applies to the Executive Council and through them to the Medical Practices Committee and he is accepted. He can then qualify for an Initial Practice Allowance, known as the I.P.A., which subsidises him for the first three years. I am talking at the moment without the application of the interim award—I will make a comment on that afterwards if you wish me to, because we have made a selective differentiation in favour of this type of entrant in our allocation within the distribution scheme of the interim award. During the first year he is allowed a grant of £600 per annum without any conditions whatever. In the second year he has to show a return of how he has done, and a ceiling is fixed. He is entitled in the second year to the sum of £450 provided there is room in his return between his receipts and the ceiling. It can be made up to the extent of £450. Now there is one condition tied to that. In the first 12 months he must have acquired 150 patients on his list. That is to show that he is honestly trying to build up a practice. As regards the third year of the I.P.A.—he is allowed a maximum of £200 provided his return does allow that against the ceiling. The Initial Practice Allowance ceases after three years, and in order to qualify for the third leg he must have built round himself a list of 500 patients or thereabouts within a very narrow margin. So that is a considerable inducement and a help to a young man starting.

1562. *Chairman*: When you say within a very narrow margin, you mean below?—If he had 495 that would be accepted.

1563. But if he can get 1,000, well and good?—That is all right, but if he had 1,000 his income would have absorbed the ceiling of the grant.

1564. *Sir David Hughes Parry*: Will you tell us about any betterment that has been applied here?—We worked out a scheme ourselves in the General Medical Services Committee first and then told the Ministry we agreed with them that the very first thing we should do with the interim award was to allocate it where the shoe pinched most. Therefore we did, out of the 5 per cent. for the profession, award these boys the whole of 25 per cent. of our then claim.

Instead of giving them an interim 5 per cent. we gave them 25 per cent. bringing the £600 allowance up to £750 and the other legs proportionately.

1565. There is a control on the putting up of a plate in a particular area?—There is control by the Medical Practices Committee. The Royal Commission is familiar with the Medical Practices Committee?

1566. Will you tell us very generally the composition of it?—It was set up at the time of the Act in order to obtain an equitable distribution of doctors throughout the population. It was regarded by Parliament then that there were too many doctors in some places and too few in others. The Medical Practices Committee—which consists, I think, of seven medical and two lay members plus secretariat—have classified all the areas of the country according to the numbers of patients per head of doctors. And they have taken two lines. They are rather arbitrary; the lines are these: upper 2,500 and the lower 1,500. If an area has an average number of patients above 2,500 per doctor, that is called a designated or open area, and any doctor can have the right to apply to practise in that area and go in and receive this Initial Practice Allowance. The area between the 2,500 and the 1,500 line is called an intermediate area. A doctor may apply to go in and he will generally be accepted, but he does not get the allowance. The third area is where the average number of patients per doctor is 1,500 or less that is declared a closed area because, in those circumstances, it is considered that that area is adequately doctored.

1567. *Chairman*: Dr. Davies, we must not pursue this for more than a minute or so, but are there a considerable number of practices in each of those three categories?—Yes, Sir.

1568. It is not equal thirds, but quite a lot in each?—Yes, but the tendency throughout the years has been a levelling down to the intermediate. There has been an entirely new distribution.

1569. Yes. Fewer open and fewer completely free?—Yes.

1570. *Sir David Hughes Parry*: There is only one other matter on that. In paragraph 110 of the memorandum there is an expression—and I was not quite certain what the significance of that

expression was. It is the third sentence:—

"Moreover the comparative freedom of members of other professions to change employment or to move from from one area to another must be weighed against the monopolistic control which virtually exists in medicine today and isolates doctors from such freedom."

It is really the monopoly exercised by the Medical Practices Committee?—*Dr. Wand*: No, the fact that we have a National Health Service and that practically all people in the country—the vast majority—are registered with doctors means not only that the doctor cannot change easily or at all indeed from public service to private practice, but that he cannot change his place of work very easily. Indeed it is practically impossible once you are set in one place to get established somewhere else; very, very difficult indeed. It is very difficult to get from one section of the profession into another section for reasons which, if there is time, Mr. Holmes Sellors will no doubt tell you. It is almost impossible—or virtually impossible—for a doctor to get employment in something else because he is only qualified to practise medicine. He cannot escape into industry or commerce because he has no training.

1571. *Chairman*: That is the general point you are making?—All those four points are intended to be brought in.—*Dr. Davies*: One point which will give Sir David his direct answer on the freedom of movement of general practitioners is that in the nearly ten years that have elapsed since the Health Service began it has been possible for only about 25 doctors to exchange practices.—*Mr. Holmes Sellors*: The only thing I would like to add to that is the practical impossibility of any consultant who is wishing to obtain ancillary services, of doing his work anywhere except in a hospital, which will almost certainly be controlled by the State. In other words you are confined to working in premises and under conditions that are owned by what one might almost call a monopoly.

1572. And private practice?—You can do some private practice but the needs of modern surgery and medicine sometimes make the amount you can do outside hospital negligible.

1573. But there is a trend towards maximum part-time among consultants?—There is a trend, yes, rather on the grounds of, shall we say, freedom, than necessarily the building-up of any large private practice that might intrude on that free time.

1574. *Mr. Bonham-Carter*: Was there much movement before the war?—*Dr. Wand*: Yes. A doctor started off very often in a highly industrialised area and in the course of time he wanted to change his place of work. He went, for example, to the south coast and bought a practice there. But today if the doctor is in an industrial area and finds one of his family has asthma or finds he himself cannot cope with the strain of an industrial practice, it is practically impossible for him to get a vacancy elsewhere.

1575. *Chairman*: I do not suppose you can quantify that particular thing, but you might have a look at it sometime and see if you can. You say it is considerable?—There are a lot of doctors who want to get into another type of practice. We have a little evidence on emigration which shows that some doctors, wanting to get out of practice, have gone out of the country altogether.

1576. *Mr. Bonham-Carter*: I do not question that there is difficulty today, but I was interested to hear that there was a fairly free movement before the war. I would just like to ask you one more question in relation to that. I take it that many doctors before the war started off as a junior partner in a partnership?—Yes.

1577. Was there more movement when they ceased, as it were, being a junior partner? There is a good deal I can see happening then. They leave the position of junior partner and go off into a bigger practice?—Yes. If a doctor did not like the district or his senior partner or that type of medicine, he could buy a practice in some other part of the country.

1578. Yes, but would an older man move much before the war?—In his later years, yes. A man of my age in an industrial area would feel perhaps that he wanted a change and move south.

1579. There is one other thing. You implied in one of the things you said that people in other professions would

find it quite easy or much easier to change their horses. Is that what you really think?—Yes, and I think I can justify that statement. A doctor is qualified to do medicine. There is really nothing else that he can do. But you will remember this morning I referred to the accountants who had 164 or so directorships between them. This article set out to show—this article was only one of a series, I understand—that if you wanted to diversify your life ultimately and go into the field in which you could be most successful, the best thing to do was to start off by qualifying as an accountant because thereby you could ultimately go into so many different fields. You could use your accountancy knowledge either in banks, insurance companies, in industry, in commerce, on your own account or with somebody else, or just do accountancy for which you were trained. Even in law—I think Mr. Cooke will agree—many lawyers have by their legal training made themselves more proficient and more useful to people in trade and commerce outside a lawyer's office. But a doctor has nothing. Perhaps one of the best examples is the politician.

1580. *Sir David Hughes Parry*: I think we have dealt more or less with partnership agreements—we dealt with those yesterday?—Yes.

1581. The fourth method of entry was the present equivalent of buying a practice under the old scheme, and perhaps you could say how is that controlled?—Buying practices?

1582. No, the taking up of a vacancy.—*Dr. Davies*: A vacancy is advertised by the Executive Council, the applications are accumulated, considered and short-listed, and a selection made. Then in England the decision of the Executive Council is vetted by the Medical Practices Committee. It may be confirmed or not.

1583. In other words the Medical Practices Committee has a certain measure of control over this means of entry?—Yes, a very great measure of control.

1584. As well as over the method of setting up a plate?—Yes.

1585. I think you did mention earlier what the membership was?—I think I am right—perhaps Dr. Stevenson will confirm—it is either six or seven . . .

—*Dr. Stevenson*: Seven, one of whom is a barrister.

1586. So that the majority in control would be medical men?—Yes, appointed by the Minister.

1587. *Mr. Watson*: Arising out of that question, *Dr. Davies*, would you agree that some of the limitation of freedom placed on the general practitioner coming under the jurisdiction of an Executive Council is in the interests of the practitioner himself?—

Dr. Davies: I think I can go so far as to say that the profession, in entering the service, did accept the Act and its implications.

1588. And one of the implications of the Act was to protect and at the same time limit?—As far as the Executive Council is concerned—you quote the Executive Council—it has a comprehensive constitution and it is assumed that it protects the interests of all parties including the patients, the doctors, the dentists, the pharmacists and the opticians.

1589. *Chairman*: *Mr. Holmes Sellors*, we are not going deeply, as you will see, into the question of consultants now. We shall probably do that in greater detail with the Joint Consultants Committee and the Colleges. But if I have understood it correctly, so far as the general practitioners are concerned the claim that has been made is for the 29 per cent., of which you have had 5 per cent., to go globally to the pool; you could then adjust the distribution within the pool, as between different parts of the general practice profession, by negotiation with the Ministry. As far as the hospital service is concerned, do I understand that the claim is for a direct increase of a uniform percentage of salaries at all levels?—*Mr. Holmes Sellors*: That is so.

1590. Including merit awards?—That will come before you in the near future. Merit awards, you see, have had no adjustment at all, and so we have had to calculate back.

1591. I was dealing really with the claim that has been made. In our public statement of 23rd April, 1957, we said:—

“That part of the Royal Commission’s task that consists of considering what should be the proper current levels of remuneration of doctors and

dentists will include hearing submissions from those professions as to the remuneration which they are now claiming.”

I understood that was in fact the claims that they made to the Government some time back. I just want to know whether the claim for 29 per cent. to all the consultants from top to bottom includes 29 per cent. on to merit awards?—There will be an addition on the merit awards.

1592. It may well be separate?—A separate claim.

1593. Otherwise what you are claiming on your side of the house is a uniform percentage addition to the existing remuneration?—To each existing remuneration.—*Dr. Stevenson*: Could we make this point quite clear? The answer is yes to this question quite definitely, but as we have indicated in an earlier paragraph of our memorandum we are putting in a detailed claim on behalf of all grades of hospital staff, and it is possible there might be some change of differentials within that broad 29 per cent.

1594. I see, yes, thank you. But of course it is particularly in the earlier stages of the doctor’s career that the comparability is nearest, and then there would seem to be a relativity that would be extendable. That is why we have been asking these questions about what happened to the young doctor at the fork, and I think it might be worth while if you could set out in a little detail just what the pattern normally is. I know it is not precise because there is considerable variety, but you could perhaps make it clearer than it is.—*Dr. Wand*: We have made a note of the various points which you have raised for clarification, and we hope we shall be able to provide you with the material.

1595. You will see, *Dr. Wand*, that we have in fact studied the Spens Reports and the Danckwerts Award as we promised in paragraph 1 of our public statement of 12th April. There are other things that will come at a later stage and which we will bear in mind, but you will see, we have also covered, I think, the additional statement that we made on 23rd April. That is to say that we have heard submissions from the doctors—but not yet from the dentists—as to the remuneration that they are now claiming.

If there is any point that has been missed in that I would be glad if you would draw our attention to it. But I think we have covered that matter.—I would not like to give an absolute yes without going through it in detail, but I should think on the whole we have. Indeed we seem to have been discussing some things which are excluded by paragraph 7 of the public statement. But I think we have covered most of the ground that you indicated just now.

1596. Then having covered that part, are there any other points you want to make to us at this moment, Dr. Wand? We would still, of course, have the whole of your memorandum and appendices in front of us on future occasions when we meet.—*Dr. Stevenson*: There was one remark you made, Sir Harry. You did say that so far as the consultants were concerned you would be dealing with that in detail with the Joint Consultants Committee. Of course you will do so, but I just want to make it quite clear we are here representing the whole of our members, including the consultants. Mr. Holmes Sellors will be submitting a very detailed memorandum on hospital staffs from the British Medical Association.

1597. If Mr. Holmes Sellors thinks there are parts of this case that we have omitted to cover now, and that ought to be more usefully covered now . . . ?

—*Mr. Holmes Sellors*: I do not think there is anything at the present time. There is a great deal which you might wish to discuss later when we have submitted our more detailed evidence to you.

(The witnesses withdrew.)

Chairman: We appreciate that the B.M.A. is representative of consultants, but that it is more the major mouthpiece for the general practitioners in a sense. It is not the sole mouthpiece even for general practitioners, but there are other mouthpieces for the consultants.

1598. *Sir David Hughes Parry*: We did bear in mind that you were going to submit further information on consultant matters and therefore I personally did not think that any useful purpose could be served by going into them today.

—*Dr. Wand*: I think the only purpose of Dr. Stevenson's remark was that I think he gathered from what you said that in spite of these further documents that are coming from the British Medical Association most of the matters contained in them would be discussed almost in their entirety with the Joint Committee and the Colleges. I gather from what has been said that is not so.

1599. *Chairman*: I think Mr. Holmes Sellors himself is a link with these other bodies.—*Dr. Stevenson*: My only wish in saying that was to make it quite clear we are not a general practitioner organisation; we are representing the whole of the profession.

1600. I realise that. Your memorandum says that. If there are any points that you think should have been covered particularly about the consultants . . . ?

—*No.*—*Mr. Holmes Sellors*: I do not think so. I think those will all come up in more detail in our case.

Chairman: Then thank you very much.

Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

7

Seventh Day, Friday, 31st January, 1958

WITNESSES

Royal College of Physicians of London

LONDON

HER MAJESTY'S STATIONERY OFFICE
1958

THREE SHILLINGS NET



Witnesses

ROYAL COLLEGE OF PHYSICIANS OF LONDON

ROBERT PLATT, M.D., F.R.C.P.

SIR RUSSELL BRAIN, Bt., D.M., F.R.C.P.

SIR HAROLD BOLDERO, D.M., F.R.C.P.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

SEVENTH DAY

Friday, 31st January, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

PROFESSOR JOHN JEWKES, C.B.E.

MR. I. D. MCINTOSH, M.A.

SIR DAVID HUGHES PARRY, Q.C.

SIR HUGH WATSON, D.K.S.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

ROYAL COLLEGE OF PHYSICIANS

Memorandum of Evidence Submitted to the Royal Commission on Doctors' and Dentists' Remuneration.

PART I

At the Comitia on 25th April, 1957, the President announced the setting up of a nucleus committee to prepare the draft evidence to be submitted to the Royal Commission on Doctors' and Dentists' Remuneration.

The following Committee was appointed:

Dr. R. Platt, President

Lord Moran

Sir Russell Brain, Bt.

Sir Harold Boldero

Dr. T. C. Hunt

Dr. T. F. Fox

Dr. M. I. A. Hunter

Evidence to Royal Commission

INTRODUCTION

The Royal College of Physicians of London was founded in 1518 by King Henry VIII. It was thus the first medical corporation in Great Britain. The purpose for which the College was founded was to ensure that "none should be allowed to practise physic but those deeply studied therein" and to this day the chief interest of the College has been the maintenance of a high standard of medical practice.

The Governing Body of the College is the "Comitia", which is a General Meeting to which all Fellows are summoned and which is held quarterly and at other times.

The College Roll consists of Licentiates, Members and Fellows. The Licence (L.R.C.P.) is granted after examination in association now with the Membership of the Royal College of Surgeons of England and together they constitute a qualification which entitles the holder to be registered to practise all branches of medicine, surgery and midwifery.

Members are elected by Comitia after passing an examination. The M.R.C.P. is recognised as a valuable higher qualification in medicine for a consultant post. There are at present about 3,680 Members.

Fellows are elected by Comitia from among the Members by selection, no examination being required. There are about 860 Fellows at the present time. It is no longer the custom to restrict the Fellowship to those who practise in General Medicine. The College

now counts among its Fellows men and women who are distinguished in all aspects of consultant practice of Medicine.

The College is thus unique in the profession in being able to draw upon the corporate opinion of several hundreds of Fellows who have been elected by virtue of their standing in the profession and who practise in all manner of hospitals.

Again, the College through its joint machinery with the Royal College of Surgeons, institutes and conducts examinations for the various post-graduate diplomas, e.g., the diploma in Child Health, Pathology, Radiology, Psychological Medicine.

In addition to medical education, which is a dominant interest, the College has many other activities. Each year it holds several important lectures and administers scholarships for medical research. It sets up various committees which report from time to time upon various branches of medicine, such as Paediatrics, Neurology, Cardiology, Rheumatic Diseases, and on matters of topical importance. These reports are often published and circulated to the Ministry of Health and other interested bodies.

Opinions of Fellows naturally differ to some extent on the degree to which the Royal College of Physicians should concern itself with medical politics. That the main function of the College is educative: that it is primarily concerned with the setting and keeping of the highest possible standards of medical practice. Remuneration, since it influences the recruitment, training and well-being of consultants, is a subject which cannot be ignored.

PART I

In 1948, under pressure, doctors agreed to enter a service in which they would be paid from public funds.* Their reluctance to rely on the Treasury for their remuneration was eventually overcome because the Government of the day accepted the reports of the two medical Spens Committees. The first said that many general practitioners had been underpaid before the war: in a publicly organised service their financial position should be improved, while that of their more prosperous colleagues should be kept much the same. The second said that, though consultants could no longer hope for the large incomes some of them formerly reached, they should be better paid in their earlier years. Both for practitioners and for consultants the difference between minimum and maximum earnings was to be reduced; but the intention of the two reports was clearly to ensure that, in the Service, the economic status of doctors in the community would be generally maintained.

It has not been maintained.

The Spens recommendations for general practitioners were translated into 1950 money by Mr. Justice Danckwerts; but there has never been a similar award to hospital doctors. In 1954, *faute de mieux*, these accepted terms which for some of the juniors represented a betterment on Spens 1939 figures of as much as 40 per cent (though the position of their seniors with the highest distinction awards was actually worsened by the revision). Since the National Health Service started, no other alteration of incomes has been made to compensate for the change in the value of money since 1939.*

To provide such compensation in full, the Spens figures would now have to be raised by at least 155 per cent,† which would give whole-time consultants a salary range of £3,825 to £6,375, on top of which they would be eligible for distinction awards of up to £2,500. The College recognises that such increases are out of the question. But in view of their experience in the past few years consultants may be excused for insisting that, if they and their juniors finally forgo the notional pound of flesh which they have never claimed, the arrangements accepted in exchange shall be such as will fulfil the Spens Committee's general intention not only now but in the future.

A year ago the College participated in a claim that 24 per cent should be added to the pay of doctors to make up for the depreciation of money since 1950. With this rise the range for consultants (excluding distinction awards) would have been £2,604 to £3,844—representing an average betterment of about 61 per cent on Spens 1939 figures, or considerably less than half of what might have been claimed. The same method of calculation would give consultants, in late 1957, a salary range of perhaps £2,700 to £4,000.

* In this memorandum no account is taken of the "interim adjustments" of April, 1957.

† Taking the estimated purchasing-power of the pound as 100 in 1938, it was 97 in 1939 and 38 in 1956 [*Hansard*, House of Commons, Nov. 27, 1956, Col. 32].

The College does not suggest that medical remuneration should rise automatically with the cost of living. It does not think that members of a public service should enjoy special protection against public misfortune. On the other hand, as newcomers to the national pay-roll, doctors do not accept the view of successive Governments that in times of financial difficulty (no longer rare) a particular patriotic contribution should be demanded from people who happen to get their pay from the Exchequer. Economies at the expense of the Civil Service and officers of the Armed Forces have become a normal Treasury reaction to stress; but they are quite unjust, since, unlike other taxes, they operate selectively against particular citizens regardless of any circumstances other than the source of their remuneration. This official reaction has been typified by the Government's refusal even to examine a claim which was based on depreciation of doctors' pay over the long period of five years. If people in public services should not be specially privileged, neither should they be specially deprived.

In a period of inflation, as is now seen very plainly, the standards of those who work in a service can be quietly reduced to more convenient levels by merely denying them the compensation that others are receiving for the decline in the value of money. Whether or not there has been any such intention as regards doctors in the National Health Service, the Governments of the past few years have certainly not shown any positive wish to preserve the conditions on which the doctors entered it.

After ten years there may well be a case for reviewing those conditions: to achieve its object, the remuneration of any group must be related to that of other people—and much has happened in these years. But the arguments for maintaining the relatively high economic status of the medical profession are as valid as when they were accepted by the Spens Committees and by Mr. Attlee's Government.

REASONS FOR HIGH REMUNERATION

The interests of the public and the profession ultimately coincide in that both require a continuing supply of able entrants to Medicine. Hence the profession must remain relatively attractive. But, apart from this, the severity of the doctor's training and the weight of his responsibilities need recognition, and his financial circumstances should be such as will allow him to do his work well.

Training

About five years after leaving school, the future doctor can qualify and take a paid house appointment; and a year later he will be legally entitled to practise independently. But many students take a longer course, either because they refuse to specialise in science at school or because they take a scientific degree on the way. Moreover, for many, registration as a doctor is only the beginning of a new stage of training. Those who intend to be family doctors may hold several hospital or other posts before becoming assistants in practice; and those who hope to become consultants must settle down to at least five years' post-graduate training and often far more. Both before and after qualification these are arduous years, making considerable demands on stamina; and in the main specialties they are also anxious years, because of fierce competition and the risk of failure.

It is true that training for many other occupations has lengthened likewise, and it is also true that in Medicine, as elsewhere, a large proportion of students (perhaps about two-thirds*) are now partly or wholly supported by grants. Hence the particular claim of doctors to a financial return for an exceptionally long course of study paid for by their parents is not as strong as it once was. But the fact remains that all doctors invest long years in training, and some still do so at heavy expense to fathers whose income disqualifies them from receiving grants towards maintenance or fees.

Responsibility

The National Health Service differs fundamentally from State medical services abroad in which every doctor is subordinate to a superior and those at the periphery can be of low grade and paid accordingly. Medicine in this country is based on the contrary principle that every fully trained member of the profession is a doctor in his own right: he is responsible not to any central authority but to his patient and his conscience.

* Report on Enquiry commissioned for Mountford Committee, 1957.

Though the new Service has helped doctors to consult one another, their personal responsibilities increase as Medicine grows more intricate. As specialties multiply, it is more and more important for the family doctor, as his patient's personal guardian, to decide correctly what specialists shall be consulted and whether (in the particular circumstances) their advice shall be taken. Similarly in hospital, when diagnosis and treatment are undertaken by teams of doctors and members of allied or ancillary professions the burden is often heavier on the consultant who takes final responsibility and has to give the decisive opinion. The practice of Medicine is far more successful than formerly, but at all levels it is also far more difficult. To ensure that a patient gets the full benefit of modern methods, yet suffers no unnecessary injury of body or mind, calls increasingly for knowledge and judgment—to say nothing of those qualities of character which may be equally important to the sick person, though commonly taken for granted.

In contemporary society, responsibility does not by itself rate highly for pecuniary reward: the railway signalman is poorly paid, though his errors can be disastrous. The reason why the public have in general been glad to accord the good doctor high remuneration is that his continuing responsibility for life and death is borne at an intellectual level. Day in, day out, any failure to observe and to think—to notice and deduce—can be fatal to the patient. Only intermittently aware of the responsibilities of the profession, the layman is apt to play them down; but the doctor is conscious of them all the time, and is often appalled by the growing complexity of a task which must never be allowed to become a mere routine.

Conditions of Work

If the community want medical care of a consistently high standard, it will have to grant the doctor a position in which he is neither overworked nor financially harassed—in which he can not only keep physically fit but also retain and cultivate the interests of an educated person. That is the price the community must be prepared to pay for having doctors in the British tradition of personal responsibility—doctors who will bring well-balanced judgment to bear on each individual case instead of applying a routine or following instructions.

Similar needs are felt in other professions. Many a schoolmaster or engineer spends on household duties, or on efforts to earn a little money, the leisure which, if he is to give of his best, should be used for reading, reflection and relaxation. But the situation of the doctor differs in that anyone who accepts the care of patients, who put their trust in him, is in a sense on duty twenty-four hours a day: the serious case is never out of his thoughts. For the family doctor, this unlimited obligation sometimes means periods of almost incessant work; and, much though he may like the vocation he has chosen, the combination of mental and physical fatigue is not well borne in an impecunious home, with a wife pressed into the service of the practice. For the consultant, responsibility to patients involves a special duty to keep his knowledge up to date, and a favourable environment is essential if he is to make full use of his opportunities for learning, teaching and investigation.

People outside the profession often suppose that Medicine advances only through the labours of whole-time research workers, and that those who practise in the hospital or the home do little more than apply knowledge gained in the laboratory. But actually medical progress depends largely on the innovations and discoveries of those who treat the sick. Much of the interest of the clinician's task lies in his efforts to improve on what has been done before; and if Medicine were ever to be depressed into a routine application of what is already known its spirit would be destroyed. It must either go forward or it must go back: and doctors are united in believing that the conditions of their life and work in this country, as in others, should be such that it continues to go forward.

Those who look on medical expenditure as unproductive must be unaware of the contribution that Medicine has made to the world of today and can make to the world of tomorrow. In the words of a non-medical historian, Sir David Lindsay Keir:

"Western medicine has transformed the modern world. Where it goes, life takes on a shape never known before. It makes possible the enterprises of the builder, of the agriculturist and stock-breeder, of the miner, of the engineer . . . of all who are bringing prosperity to peoples who have been condemned for centuries to poverty and the frustration and suffering that goes with it."

By its share in this work, British Medicine won high respect abroad, and despite vicissitudes it has so far retained that respect by its continuing contributions to discovery. But it can scarcely hope to go on making these contributions if support is weakened at home.

THE PRESENT SITUATION

Doctors in the National Health Service are paid in 1950 money which has lost about a quarter of its value. Naturally even this degree of inflation has seldom spelt actual hardship for those consultants who have relatively big incomes derived from the larger distinction awards and from private practice. But in the hospital service there has never been much room for retrenchment in the budgets of junior staff, and to many of these the loss of even a tenth of their income was a domestic disaster.

For an important minority, an additional cause of financial distress is the fact that they have not secured the more senior appointments which they could reasonably expect. Whereas the Spens Committee supposed that, after training, a man would normally become a consultant about the age of 32, the failure to create enough consultant posts, which are needed by the Service, has meant that many able men—some of them now of middle age—who have been given exclusive specialised training, are not yet getting the consultant's pay to which their merits and experience entitle them. Commonly they had years of war service behind them before entering Medicine; and now, in their late 30s and early 40s, they are trying, against almost impossible odds, to maintain a professional standard of life for themselves and their families while also continuing their struggle for professional advancement. The Service is saving money not only by paying their grade too little but also by preventing them from reaching a higher grade; and if this is intended as an economy it is certainly a very expensive one. It is these doctors, and their juniors who see what has happened to them, that are starting to emigrate—not from Medicine but from Britain and the National Health Service, though our hospitals still have waiting-lists for consultation and care.

The responsibilities borne by many of the younger specialists—working (or over-working) as registrars and senior hospital medical officers—are often indistinguishable from those of consultants: indeed a registrar may be deputising officially for his consultant chiefs, very often performing major operations without supervision, and taking full charge of wards and out-patient clinics.

For such a man the conditions offered are no longer tolerable. His remuneration—appropriate enough before it was devalued and while he was still in training—is patently insufficient for the experienced doctor he has now become. Before the interim award, a senior registrar on the top salary of £1,400, with a wife and two children, had a purchasing-power, after taxation, of well under £500 in pre-war money*, whereas on the Spens recommendations he would have had—when perhaps five or ten years younger—at least £1,100 (less about £140 in taxes).

Earning less than many artisan patients younger than himself, he has no security whatever until he succeeds in gaining a consultant post—perhaps after the tenth or twentieth application, or perhaps never. And to obtain work he may have to move his home repeatedly, at a cost he can ill afford. Yet, unlike a registrar before the war, he can seldom relinquish his specialty in favour of general practice, which no longer welcomes young men trained in other branches.

Nor is the young consultant any longer well off—though he will often be chosen from fifty applicants. His appointments may give him only a few sessions, and he will have little or no private practice to supplement what he earns from the Service. Even in later years, when he has reached the middle of his salary scale, a full-time income of £2,650 will give him after taxation (if he has two children) the equivalent of about £800 a year before the war*—compared with the Spens recommendation of £2,000 (less £360 taxes).

To the wage-earner these sums sound like great wealth; but the combination of depreciating money and an almost stationary level for surtax has transformed much of the substance into shadow. For the young consultant, with his over-riding duty to make the most of his exceptional ability and hard-won knowledge, many of the economies of the

* See *Hartard*, House of Commons, April 9, 1957, Col. 113.

wage-earner are not only difficult but wholly improper. To do his work really well, and to be fit in every way for it, he must have books, service if possible, and time for study, reflection and recreation, and he must not feel obliged to sacrifice these things as the only means of bringing up his family in the way he thinks right.

THE FUTURE

Recruitment to the Profession

In the long run the gravest defect of unsatisfactory conditions of life or work would be lowering of the quality of entrants to the profession. In a calling as old as ours, this effect might be long delayed; and such things are always hard to assess. But the fear of qualitative deterioration is very much in the minds of those who understand what capacities good practice already demands, and know that to cope with the Medicine of tomorrow we need a generation better than their fathers.

The coming of the National Health Service has done little to make Medicine more attractive to the young, and a good deal to make it less attractive. Probably most doctors now think some such service necessary; but their favourable comments are seldom such as to kindle positive enthusiasm, and their praise is generally less audible than other people's complaints. Particularly discouraging to the schoolboy or his parents, is the fact that many doctors have not found the places they hoped for, either in general practice or in the specialty for which they have trained. Whereas much disapproval of the Service is inevitable in men who were brought into it late in life, it is disturbing in those who entered it young and keen. To nearly all, of course, the work itself remains absorbing; but their vicissitudes and financial circumstances—to say nothing of their emigration—must often dishearten possible successors.

The needs of Medicine for both brains and character are such that we cannot afford to lose a single first-rate person who wants to be a doctor. Yet we are bound to lose many if the impression develops that, through public organisation, Medicine in this country is becoming a depressed industry, which Governments are content to see reduced to a lower social and economic level.

Regarded as a means of livelihood, Medicine may so far have lost little of its attraction for people accustomed to considerably lower incomes than it provides, but it now seems to have less financial appeal in the circles from which doctors in the past were chiefly drawn. Whereas formerly it was very much a family profession, followed by successive generations, there is reason to think that fewer doctors are now putting their sons into it.* For this two explanations are advanced. First, many of them do not like the new conditions. Secondly, many others, especially if they have several children, can no longer afford to give a boy five or six years' unpaid training. Their income is high enough to prevent their having any of the help that other parents get from public grants, but not high enough for them to find several hundred pounds a year for six years for one child.

In the College's view, the contribution of family tradition to the profession has been important. At its best, the medical attitude is a fine one; and in the past a biggish proportion of entrants to Medicine already had it in their bones. That doctors, for any reason, should cease to want their boys to follow them is a symptom whose causes ought to be removed.

All will agree that, in a profession, money must not be the principal inducement to recruits: the student should enter primarily because he wants to do the work and is likely to be good at it. In Medicine the greatest rewards are not financial. At the same time, the person who is capable of doing medical work well is one who in other and often far less arduous and anxious capacities could secure at least a good living for himself and his family. If the nation wishes doctors to be paid from public funds, the profession is entitled to insist that future entries to it shall not be prejudiced by the imposition of a new *negative* inducement, which prevents the recruitment of valuable people who would otherwise make this their vocation.

* Of the students admitted to medical training at Universities in 1955, 17 per cent of the men and 12 per cent of the women had medical fathers. [Report on Enquiry commissioned for Mountford Committee, 1957.] The College hopes to provide comparative information in Part II of its evidence.

Financial Incentives within the Service

Among those who have entered the profession, differences in remuneration are necessary (1) to encourage entrants to undergo especially long training for work in which they are needed, and (2) to encourage effort and reward achievement.

At present the monetary advantages of training as a specialist in medicine, surgery, and obstetrics do not conspicuously outweigh those of early entry to general practice. The College believes that these advantages should be substantial and clearly evident. It is particularly concerned at the possibility that some of the gifted young doctors who are required as physicians will see no sufficient reward for the long years of additional training and competitive insecurity which they must now face.

Though it agrees that in a publicly organised service disparities of income should be less than they were in the old days of purely private practice, and though it regards better pay for the younger hospital doctors as particularly urgent, the College thinks it important to continue the professional system whereby exceptional ability can earn exceptional reward. The increment of 1954 reduced the differentials: and, at a time when surtax still removes a substantial proportion of any large salary, this process cannot be carried further without abolishing much of the material advantage formerly earnable by special effort and special capacity. In Medicine, as in other comparable occupations, a leading position, with the responsibilities it entails, should still bring reasonable affluence to the man who attains it.

The Spens Consultants Committee put this need very clearly, and proposed that it should be met by giving distinction awards to consultants whose work was regarded by their fellows as especially meritorious. To decide which consultants have earned these awards is not easy, and the Spens innovation in the distribution of public money has naturally not escaped some criticism. But the College believes it to be a good one, which should certainly be preserved.

In the National Health Service, as elsewhere, policy should be decided first, and incentives should then be created to subserve it. This has not always happened, and the effect of some of the existing unplanned and accidental incentives needs re-examination. For instance, the Inland Revenue authorities have played their own supplementary part in the denial of Spens, to such effect that consultants are actively discouraged from holding whole-time posts, in which they are commonly denied tax relief on obviously necessary professional expenses such as books, journals, and membership of societies. Nobody, surely, has intended this disincentive.

Revision of Remuneration

When suitable ranges of remuneration have been chosen, and accepted, they will still have to be considered from time to time. The value of money is always changing, and so is the balance of needs within the Service. At best, all scales and grades are crude, and they must be judged by their effects.

The Whitley machinery, which should be capable of adjusting remuneration to needs, has not worked well. The Medical Whitley Councils have not been a place for serious discussion; for the major decisions have been made beforehand, and the function of the management side has been chiefly to give expression to the Treasury's "No"—to which no effective answer is possible since arbitration is available only if the two sides agree to it. The result is that increases of pay have been obtainable only through periodic crises of an increasingly political character, which have harmed profession and Service alike.

The finances of the Service, and of those who work in it, obviously need a more stable foundation than the mood of successive Chancellors; and the best hope of arranging changes of pay in a seemly manner, as and when they are necessary, seems to lie in the interposition of a neutral body between the two interested parties—the Government and those who work in the Service.

Drawing attention to a comparable proposal by the recent Royal Commission on the Civil Service, Lord Moran has proposed that a small permanent committee should be established to keep National Health Service remuneration continuously under review and advise the Government accordingly. The College gives full support to this proposal.

CONCLUSION

The Spens Committees proposed that, in a publicly organised service, the economic position of the profession in the community should be broadly maintained, or (in the case of its poorer members) improved. This proposition was accepted by the Government of the day, on behalf of the nation; and the College hopes that the Royal Commission will wish to reaffirm it with all the weight of their authority.

The same permanent validity cannot, however, be claimed for the monetary terms by which the Spens Committees sought to translate their proposition into practice. Clearly these should be negotiable and should also be reviewed from time to time in the light of experience and changes in the national and medical situation.

The claim last year was for a 24 per cent increase because the current hospital salaries, fixed in 1954, related to the 1950 value of money. As the 1954 settlement was itself based mainly on what the Government at that time was prepared to pay, the rates thus arrived at are little more than empirical. Literal translation of Spens 1939 recommendations into 1956 money would have given far higher figures.

Though the most urgent need is to improve the situation of the younger hospital doctors, differentials in the Service should not be further reduced in such a way as to diminish the rewards of high achievement.

Had they not entered the National Health Service, most doctors would have been free to increase their fees as the pound depreciated. Their present vulnerable position is a direct consequence of giving up this freedom, at the nation's request; and they feel entitled to ask both for the restoration of their relative economic status and for reasonable security against its subsequent erosion.

The State has made it impossible for more than a few doctors to earn their living outside the National Health Service. Having established this virtual monopoly, the State is responsible for the consequences to the profession and the public.

The tendency of large public services is to become mediocre, and that is what must happen to the National Health Service, too, unless it can develop—financially as in some other respects—a pattern which is new for public undertakings. As the Earl of Home said in the House of Lords on April 4th, this is the first time that the State "has had to work out a relationship with one of the great skilled professions", and to make the relationship fruitful it will need fresh methods and a fresh attitude.

In the long run the advantages to the public of a National Health Service would be bought dearly if they led to deterioration of the medical profession. Yet such deterioration is inevitable if suitable entrants are discouraged, and their elders disheartened, by a departure from the original agreements not only in the letter but also in the spirit.

The College, for its part, would not acquiesce in the continuance of such damage to Medicine in this country.

ROBERT PLATT,
President.

25th July, 1957.

Examination of Witnesses

DR. ROBERT PLATT, (*President*)

SIR RUSSELL BRAIN

SIR HAROLD BOLDERO

on behalf of the Royal College of Physicians of London
called and examined.

1601. *Chairman*: Dr. Platt, you are the President, and I suppose you are acting mainly as the spokesman for the College.—*Dr. Platt*: I am, yes; and I hope my colleagues will not hesitate to contribute whenever they feel they would like to do so.

1602. As far as we are concerned, you will find rather the same thing going on. We have allocated the task of sifting the very large and increasing number of submissions we have had from many of the medical bodies to two sub-committees. In this case Sir Hugh Watson has acted as the chairman of that sub-committee, so he will ask most of the questions in which we are particularly interested, but any member of the Commission will follow on with questions. I do want to emphasise most strongly, because I think in the past I do not seem quite to have got it across, that we want to test the facts thoroughly, and therefore we may ask a good many questions which must not in any way be taken to imply disbelief or hostility, or that we have formed particular views of our own to which we are leading up. Moreover, we may want to ask questions on matters that are not in your evidence but refer to what other people have said, and perhaps on some things on which you may be submitting evidence later on, and if you want to defer answering or prefer not to, please do not hesitate to say so; we quite understand, and we quite expect that. Then finally, there may be particular things in your Memorandum that we do not pursue. That does not necessarily imply either that we think they are irrelevant or that we accept them. I think that outlines the way in which we would propose to deal with your evidence. Just as a start, and mainly for the record in what is a public hearing, would you mind telling me a little bit about the representative character, membership, and so forth, of the College.—We have a qualifying examination, the Licentiatehip, which many young people take as their first qualifying examination in medicine. But

the College really consists of its Members and its Fellows. To become a Member of the College means that you have to pass a higher examination in medicine, which is known to be of a very difficult standard; it is an examination which nearly every consultant physician in England has passed, and which is practically a necessity in order to become a consultant in medicine. I say in England, because in Scotland a similar College gives a similar Membership. The College is really governed by the body of Fellows, and the number of Fellows at present is I think about 860. Of course one is a Fellow for life, so a good many of those are men getting old and no longer taking much part in College affairs, and a good many are abroad. So perhaps to say that there are about 400 or 500 active Fellows would be nearer the mark. They are elected from the Members of the College, and are most carefully selected once a year. New Fellows are limited in number, and no examination is required for the Fellowship. We represent really those who practise and teach and are pursuing research in medicine as a speciality—that is medicine as opposed to surgery, gynaecology or general practice, or any other branch of the profession. We do of course claim to represent first of all consulting physicians and teachers, and researchers in medicine and in allied subjects. But many consultants in the allied subjects, such as psychiatrists, paediatricians, etc., are Members and Fellows of our College, but they have also their own organisations. Then we also admit to our Fellowship a certain number of more distinguished people in other branches of medicine in the biggest sense, like radiologists; even one or two surgeons are Fellows of our College. So we really speak largely for medicine as a speciality. There are about 3,000 members—I have got the exact number here.

1603. *Sir Hugh Watson*: The figure given in your memorandum is 3,680.—I am sure that is substantially correct.

1604. *Chairman*: And you said practically nobody could become a consultant physician without passing your examinations; but equally there would be many general practitioners who are not in the consultant branch who are members.—Yes, Members of the College. I am glad you pointed that out, because that is quite true. Quite a number of people who have taken Membership have lately gone into general practice.

1605. *Sir Hugh Watson*: Can you give us any idea of how many general practitioners are in fact included among your members?—I could not; I do not know whether Sir Harold could.—*Sir Harold Boldero*: I could not give an accurate figure, but I could, if I was asked to guess, make a guess.

1606. What would your guess be?—From 400 to 500.

1607. Is it fair to say on the whole your membership is preponderatingly consultants?—*Dr. Platt*: Yes.

1608. *Chairman*: And you had a committee appointed of seven of you to prepare your evidence. Would they all be consultants?—They are all Fellows of the College. I myself am a Professor of medicine, Lord Moran you know, Sir Harold here you know, and Sir Russell Brain. Dr. Fox, the editor of "The Lancet" who was on our committee was very helpful; Dr. Hunt and Dr. Hunter are both consultants in London.

Chairman: Thank you, I think that gives us the general picture.

1609. *Sir Hugh Watson*: I notice you say in your memorandum with reference to the Chairman's first question, that members are elected by Comitia after passing the examination.—Yes, that is one might almost say, a formality. The Fellows have always reserved the right finally to say, yes we do or do not approve. In actual fact I do not think any name has been struck out for several hundred years, as far as I know.

1610. *Dr. Platt*, this memorandum of yours is marked Part I, and you indicate that another memorandum is to follow. Would you suggest that there are any subjects here which should be avoided today because they are going to be dealt with in greater detail in your subsequent memorandum, or would you like us to go through all this memorandum?—I do not think I want to exclude anything,

but I may perhaps say from time to time that we are going into this or that more carefully and hope to bring you some better and more accurate details.

1611. Coming to your memorandum at the first paragraph on page 322—this brings us right into the middle of the thing I think. You say that the intention of the two Spens Reports "was clearly to ensure that, in the Service, the economic status of doctors in the community would be generally maintained." And then in a paragraph all to itself you say: "It has not been maintained". I think the Commission would like you to elaborate on that. In the first place could you tell us what you mean by that and how you know it? How do you know the economic status has not been maintained—in relation to what?—You would agree that the Spens Committee made it quite clear they thought the remuneration of the profession and its status should be maintained?

1612. The remit to the Spens Committee laid stress on the desirability of maintaining in the future the proper social and economic status of medical practice, and I think the Commission would be prepared to accept that that was one of the objects of Spens; but I think what the Commission would like to know from you is, in what respects, and by relation to what, has the economic status not been maintained?—I should say entirely in relation to the value of the £, and the cost of living at the present time. There are of course certain ways in which some people have been hit more than others, which I could elaborate upon, but in general the statement that the economic status of the profession has not been maintained is based on the cost of living.

1613. Spens in the very well-known sentence suggested that any adjustment, any betterment as it has come to be called, should have direct regard not only to estimates of the change in the value of money, but to increases which have in fact taken place since 1939 in incomes in other professions. He had a double criterion. I would like to be quite clear about this. In this matter may I say we are very glad to have the opportunity of discussing this question with such eminent members of your profession. It was put to us quite clearly by the British Medical Association that their reading of that phrase from Spens

was that the medical profession was to be remunerated according to the change in the value of money or the incomes in other professions, whichever was the higher. I think that was quite clearly what the British Medical Association said. I think the Commission would very much like to hear the views of yourself and your colleagues on this very important aspect of the matter.—I think it would be rather difficult to uphold the point of view—if it could be proved, for instance, that all professional people had suffered to some extent—that the medical profession alone should be specially privileged. In fact, I think we say in our memorandum that we should not be specially privileged, but neither should we be specially deprived; because almost alone we are now very largely dependent on the Treasury.

1614. *Chairman*: Would you go a bit further and say that you should not be used as the means to regulate all professions, either holding down or pushing up?—I think that must be the case.

1615. *Sir Hugh Watson*: You will remember, and no doubt you are aware of the reasons why the British Medical Association put their claim in that form. They say—and of course with justice—that the doctor has an exceptionally arduous life, he has a life of exceptional responsibility, he is constantly on call, he is in a state of constant anxiety about his patients. Therefore they say that justifies doctors being singled out as a class and being insulated against the cost of living.—I should say that justifies doctors having a very sympathetic consideration in this question of remuneration, but I do not think it justifies complete insulation. You did ask if my two colleagues would also speak on this memorandum, and I would like them to do so on this.—*Sir Russell Brain*: I think that is a very complex question, because we have to consider the fact that we think very little regard is being paid to Spens in respect of changes in the cost of living, particularly in the consultant branch of the service, and especially in its higher reaches. Practically no betterment has been achieved at all in the case of the highest paid consultants compared with 1948. So that there is the fact that they are paid by the Government, and they are not in the position of private individuals so far as bargaining is concerned or putting up their fees, and they have not had the

implementation of Spens in any sense of the word. We feel there should be an opportunity for periodical adjustments in relation to rises in the cost of living. It would be quite wrong that the medical profession alone should be deprived of that, which is a somewhat different question I think, and perhaps a more important one.

1616. Were you referring to the merit awards, Sir Russell?—I was referring to them in part, but only in part; but even the basic remuneration of consultants has gone up relatively little, especially at the higher levels.

1617. You and I discussed this question the other day. May we take it that, roughly speaking, the remuneration of the two branches achieved what one might call parity in 1954?—*Dr. Platt*: I would not say that at all, no.

1618. *Sir Russell* knows why I was asking him the question.—*Sir Russell Brain*: I am prepared to answer. What I said then was first, we were negotiating under duress, and had to take the best we could get. Secondly, we regarded parity as being established in relation to the question of recruitment, which was all that the Government were prepared to consider. We also said then we had never regarded this as an implementation of Spens or as satisfying our claim under Spens; and that we should be asking you shortly, as I said then I think, that there should be a substantial increase in merit awards, which never had taken place before, and which we regard as important from the long-term recruitment point of view.

1619. I want to remove any misunderstanding about this, Sir Russell. You did feel in 1954 that the balance between the consultants and the general practitioners had been restored?—In respect of recruitment, and at that time, and without prejudice to what we felt were our just rights under Spens—all of which was made clear at the time.

1620. Your just rights under Spens at some date in 1954?—No, we said at the time we did not regard this as implementing Spens, and we reserved the right to ask for the full implementation of Spens at any future date.

1621. *Professor Jewkes*: Our difficulty there is that if in fact you go beyond the 24 per cent.—or what I understand now is a 29 per cent. increased claim, which is mentioned in your document—if

you go beyond that is there not the possibility that the balance would be destroyed once again between consultants and general practitioners?—Are you referring to basic remuneration or merit awards?

Professor Jewkes: I would like to think in terms of the earnings of consultants and the earnings of general practitioners. I have understood it is important to keep the right balance between the two, because you have got to have general practitioners and you have got to have consultants.

1622. *Chairman:* A balance that can be measured, as I think you were saying, largely by recruitment in the long run; and I think one of the Spens reports referred particularly to that aspect of keeping the recruitment balanced between the two main branches, the hospital branch and the general practitioner branch.—Recruitment is very important, but there is the short term aspect and the long term aspect of recruitment, which is an important distinction. The steps you now take might not affect recruitment for a long time. But as regards the other question, I think so far as the basic remuneration is concerned, we would agree that, assuming Spens is implemented in the way we have asked in our recent claim, that that part of the balance would be all right. But that does not prevent us reverting to merit awards; if they are to have any value whatever they must also be scaled up. There is a differentiation within the consultant branch, which is also important.

1623. *Professor Jewkes:* If they were scaled up you would not have any anxiety about destroying the balance between the general practitioner and the consultant side?—I personally should not. It is important that this difference should be maintained from the point of view of long-term recruitment; and on the general question of maintaining the attraction of the consultant branch of medicine as compared with the Bar, or industry, or other branches of work.

1624. *Chairman:* I think quite clearly, Sir Russell, you put two quite separate points. One is the relative attraction of two branches, the general practice and the hospital service; the other concerns the spread of remuneration within each of those branches, and on the second one you feel you want to come forward with

something about the 'merit awards. But taking the two branches as a whole and disregarding the internal distribution within them, you would still feel that at the present time there is a balance that is not very far wrong. I think that is what you said.—Yes; taking as an example our recent claim, and also the general practitioner . . .

1625. Each of you have made at the moment the same claim. There is no question, for instance, of the hospital side of it being 129 per cent. and the general practitioners 29 per cent.?—No.

1626. And to some extent you are not representing today one side or other of the profession, although most of your members are on the consultant side.—*Dr. Platt:* We like to think we are considering the interests of Medicine as a whole; but I think we would be wrong to say we are a body which represents general practitioners—that would not be true. But we are very keen on the good of Medicine as a whole.

1627. *Sir Hugh Watson:* Following what you have said, there are various complicated 'matters which have been brought before us with regard to the distribution of general practitioners' incomes. Would you rather we left that to other people to deal with?—I would really; with the exception that I would like to make a remark that I think sooner or later there must be some kind of treatment of general practitioners' incomes which does not entirely depend on a per capita payment. Just as in our own branch of the profession there are men who have clearly shown greater ability than average, and so on, and are being given merit awards, I think it is quite clear in general practice also there are some first class people who are doing a far better job than the average man. I think it is a pity myself—this is my personal view—that there is not some way of rewarding them. But what that way should be I would rather not go into, because I do not think it is a matter on which I have the knowledge and information.

1628. It was also the view of the Spens Committee on general practitioners, as you know. They suggested if the recruitment and status of the profession were to be maintained, men must be able to feel that more than ordinary ability and effort receive an adequate reward. You

know the only way at the moment of achieving that is by what has been called "head-hunting." I was referring, when I asked you the first question, to a rather different matter. You know there is a pool, and there are various intricate means for dividing that pool among the general practitioners. Perhaps you would rather we dealt with that with other bodies.—I think so, yes. I think that is a complicated matter on which I have no special information, and I do not think I could be of very much help to you.

1629. *Professor Jewkes*: We have had it put to us so often that if only some way could be found of rewarding the general practitioner of more than average zeal and ability, that method should be followed, but you rarely get suggestions as to how that should be done. If someone, even speaking only for himself, has ideas about it and could give us some suggestion, it would be a help.—Is there any reason why they should not have a merit award?

1630. This is one question we asked the British Medical Association last week. Do you feel such a system could be operated?—I do not at the moment see any reason why it should not, but there may be reasons that I do not know about.

1631. *Chairman*: Would you think it would be, from your knowledge, more difficult to administer than in the hospital service?—Yes, very much more difficult.

1632. There is no second degree method, there is nothing at all parallel to the membership of the College of Physicians, the College of Surgeons or any of those? Would you think, for instance, the development of a College of General Practice holds forth any possibilities?—Yes, I do think so; but I do not think it is any good rushing in to the field of higher examinations. A great deal of the quality of general practitioners does not depend on that kind of thing, and I think it would not be wise to go rushing into a higher examination for an estimate of capabilities.

1633. *Sir Hugh Watson*: Can you accept Professor Jewkes' invitation and give us any help on this matter as to how it could be achieved?—No, I do not think I could go any further; it is an extremely difficult question.

1634. *Sir David Hughes Parry*: You will have an opportunity between now and the time when you submit Part II of your evidence to think about this matter and give us what assistance you can.—I do not think I could possibly do that without consultation with the bodies primarily concerned, and really I think it would be better for you to speak to them.

1635. *Chairman*: At any rate there is one positive statement. You would like to make changes; a pure capitation fee is not the sole judge of ability in general practice—the pure number of patients on the list?—Yes.

1636. *Sir Hugh Watson*: Dr. Platt, you know the Spens remit was concerned with two things, maintaining the economic, but also the social status of the doctor.—Yes.

1637. It has been suggested to us that the social status of the doctor—and probably this is referring again principally to the general practitioner—has suffered on account of remuneration. What would your view be about that?—On account of remuneration, or on account of the National Health Service in general?

1638. No, firstly it is put to us that his social status has been diminished by the way in which his remuneration has been dealt with. Would you have any views about that?—I think the whole profession suffers when there are periodic crises like the recent one which reached its height before this Commission was brought into being. I think the whole profession suffered as a profession. I think it is extremely undignified to have to make these pay claims, and so on, and I think it a great pity that successive Governments have failed to initiate any kind of review of medical salaries.

1639. I think you and I both feel we want to look to the future rather than to the past. I was not meaning that. It has been suggested to us that the doctor has suffered in his social status because he cannot afford to employ appropriate help in his house; his wife has got to be at the end of the telephone all day; he has got to be dragged from the top of a painter's ladder to go and attend an urgent case. Do you feel that the social status of the doctor in the

community has suffered in that way because of his remuneration?—I should think it probably has, but I think these are difficult things. I think, as Sir Russell was saying, there is a long-term effect of these things which is very difficult to calculate and to foresee. The profession, I think, has sufficient status in the eyes of the public to keep fairly high for a long time; it is not running down too badly. One of the difficulties is, as you know, that there has been a social revolution going on for many years now, and the medical profession are not the only people who have not got resident help in their houses and have to do their own work. You have to balance it against the situation of other people at the same time.

1640. *Mr. McIntosh*: Would you say there are a lot of factors involved, quite apart from remuneration, in the loss of social status in the Service?—A great many doctors did feel that very much, that as part of the Service the public tended to look upon them as servants rather than advisers, and that it had altered their status. I do not think that really has happened very much in the consultant branch of the profession.—*Sir Russell Brain*: Except possibly among the junior members of the hospital staff, where there is certainly a feeling that they have suffered a loss of social status, which may be in part due to factors other than finance. That is the feeling one hears expressed when talking to them.—*Dr. Platt*: It is very difficult to say how much depends on remuneration.

1641. *Chairman*: Do you feel for instance, that the generally higher level of education in the community as a whole has meant that the distance in knowledge, and therefore in standing, between the most highly educated doctor and the ordinary public is less than it used to be, and that that has had some effect on the relative circumstances?—Yes, I think that is undoubtedly so. The kind of people I see in the out-patient department today are not the depressed poor that one used to see in the nineteen-twenties. There is a great change in that respect.

1642. *Mr. McIntosh*: You did say the consultants are feeling this probably rather less than the general practitioners. Are there any factors in the nature of

general practice which might make the general practitioner feel that his status has been lowered? I am thinking particularly of reference of patients to hospitals.—I think this is one of the things which has depended on the enormous developments in Medicine in the last thirty years. During my professional lifetime the status of the general practitioner was rather felt to be going down—there were so many things which he could no longer do which the hospital people could do. Now I think, and very many people believe, there is a renaissance in general practice, practitioners are now able to use so many of these modern remedies, and to be the first people to be able to use them, long before the patient ever thinks of going to a hospital or a consultant. People are beginning to realise now that general practitioners are a very important part of the Service. I think they had reached a low level and are going up again.

1643. And the public are beginning to realise that?—The public will realise it sooner or later.

1644. *Chairman*: There is always a delayed reaction by the public?—Yes.

1645. *Professor Jewkes*: This is a most interesting point. Do you think it accounts for the fact that already there seems to be a tendency for waiting lists in hospitals to decline, that the general practitioner is able to handle more patients in the home and therefore relieve some part of the pressure on the hospitals?—These things are extremely complex. There is just no doubt at all—I have the greatest difficulty in showing my students a case of pneumonia, because pneumonia is nipped in the bud and treated at home, and in many cases it is pretty well harmless now. On the other hand our kind of Medicine and investigation and so on, which we can do in hospital, is now applicable to a large number of disorders which could not previously be treated, so our waiting lists grow, but of a different kind. Which one is catching up on the other I could not say. You tell me our lists are actually going down—I do not know.

1646. This is a statement which has been made before us. Could I ask one question on page 322 of your memorandum? You mentioned there the claim for 24 per cent. We are particularly interested in what the probable reactions would be, if consultants' earnings went

up, on the position in the universities. Would you assume that the salaries of medical professors would be increased *pari passu*, because this is always a very difficult matter?—It is a very difficult matter indeed; and having been a University professor for the last twelve years, I am not ignorant of its difficulty. My view always was that as a Professor of Medicine I am two people—I am a University professor and I am also a physician of the hospital. As a University professor I do not see any particular reason why I should be paid more than another university professor, but as a physician in the hospital I see no reason at all why I should be paid any less than any other Physician. I have said that before; so you are dealing with a person who has two lives.

1647. If anything happens in one branch it will filter down to people on the outside. Have you any suggestion as to how to deal with it?—We have been very beneficial to people on the outside.

1648. *Chairman*: That implies that if ever anything happens to clinical medical professors, inevitably that does immediately react on the other University professors and downwards; is that right?—It does, yes. I do not think, honestly, if they really knew the life I lead, that they would really want to be paid on the same level and do the same amount of work. I am not saying they do not work hard, but they have much more time to do the work they want to than I have; that is the distinction.

1649. I am assuming for a moment that the right sort of relationship were today established between the medical professors and the rest of the University staff; then if one section is very much amended that would probably react quite sharply, or almost similarly on the other sections?—It is bound to have a reaction, yes.

1650. *Sir David Hughes Parry*: There is another possible implication in what you have said; that for the work at the University you might be paid the ordinary range of University salaries, and for the work in hospital you might be paid from hospital resources. Would you have that in mind?—This actually happens. Merit awards are not things we want to discuss at this stage, but most professors will have awards of some

kind, and these are paid out of Health Service funds. I believe it is paid to the University, who then pay it to their professor—that surely comes out of Health Service funds and not out of University funds.

1651. But there is a substantial difference between the amount the medical professor receives and the amount the arts professor receives. I thought it was the implication that a part of that might be taken from the hospital resources rather than University resources.—There are other reasons why a medical man might have to be paid more. There is the question of recruitment again. He has other alternatives in his profession which perhaps a professor of Latin has not got.

1652. But which the professor of law might.—Very much so.

1653. And of economics?—Yes, certainly.

1654. *Chairman*: Broadly speaking the professor is usually somewhere near whole-time, in theory, is he not?—Yes, since the war. Before the war very few Universities had whole-time professors of clinical subjects. Now most Universities do, in the main branches.

1655. *Sir Hugh Watson*: Could you clear a point in my mind? Does a whole-time professor also have hospital duties?—Yes, I am a physician to my teaching hospital, and I have a unit with as many beds to look after as my part-time colleagues who are in consulting practice.

1656. You are not a whole-time consultant?—No, I am called a whole-time professor of medicine, but I spend probably more than half my time on my hospital duties. I cannot teach, I cannot show people what the practice of medicine should be, without having patients.

1657. *Chairman*: That is the traditional way in which the practice of teaching has developed—the association between the University professorship and the hospital?—Yes; but until comparatively recently most professors were really part-time consulting physicians. They spend part of their time in teaching—they all, in the teaching hospitals, spend time in teaching, but the professor also has other administrator's duties as well. You were saying I was equivalent to a whole-time physician.—*Sir Russell*

Brain: On the other hand many consultants are part-time in hospital and part-time private practice.—*Dr. Platt*: I do no private practice. A whole-time physician would spend all his time looking after his hospital patients—and of course doing some teaching as well in a teaching hospital; whereas I have University duties in teaching and research beyond what the average whole-time physician has.

1658. *Sir Hugh Watson*: The result of this curious jargon that we speak is that you are a whole-time professor and a whole-time consultant, but being a whole-time professor you spend half your time professing and half your time being a consultant; is that right?—If you like.

1659. I think we have got your views about the earlier part of this memorandum. You deal quite shortly with the reasons for higher remuneration, on which we have touched already, and then you come on to the question of training, and from there on to the question of grants. When we were dealing with the Joint Consultants Committee, we raised this question of grants, and *Sir Russell Brain* said that the Royal College of Physicians had more information, and that he would rather it should be left over for the College to deal with. Have you any figures you would like to give us with regard to these grants? You say here that perhaps about two-thirds of students are maintained by grants, wholly or partly.—I think the figures we are compiling will show that to be approximately correct, and also that the proportion of medical students who get grants was rather less in the Universities as a whole than the proportion of all students who get grants.

1660. Do I gather from what you say that these figures are not yet fully assembled?—*Sir Harold Boldero*: They are part of our next memorandum. Would the Commission wish us to abstract that now?

1661. *Chairman*: If it is coming next time, you can give us it then.—*Dr. Platt*: The only reason why I am a little reluctant to talk about them now is because some of these figures have not been finally checked up, and so on. We may want to revise them a little.

1662. We are quite willing to wait till the next time.—Apparently it would be about 61 per cent. of male medical

students as compared with 81 per cent. of men in all faculties.

1663. There is one question on that difference which you might be able to answer; is that because of the operation of means tests?—I presume it is, yes.

1664. *Sir Hugh Watson*: We have in front of us, *Sir Harold*, the regulations issued by the Scottish authorities for dealing with this question of grants and testing the income of parents. We do not have the English regulations in front of us, and perhaps if you could know about these it might be helpful next time. I am told the Commission have them, so they will be available to you too. As you know, these regulations provide what is to be taken into account by way of deduction from the parents' income before the figure is fixed for the amount of his boy's award.—*Sir Harold Boldero*: These apply to both central and local authorities?

Sir Hugh Watson: Yes.

1665. *Chairman*: You have, I suppose, no information as to what proportion of these students are the sons of doctors, or what proportion of them come from quite other walks of life? It might be material to this question.—We have no actual figures, but we might be in a position to give you a view. We have had no hard and fast figures, they are mostly impressions.

1666. One other question in relation to that, which you may be answering in the next part of your evidence. These figures you are giving do not relate only to those who become physicians, but to the whole medical profession?—Yes.

1667. *Sir Hugh Watson*: On page 324 of your memorandum you say the personal responsibilities of doctors increase as medicine grows more intricate, and as specialties multiply. I think the Commission would like to hear you a little about that, because it would seem to them that these different specialties rather provided aids to the general practitioner.—But it still remains for the general practitioner to sense out at a much earlier stage the need for these aids and that responsibility has increased enormously, I think, with the growth of Medicine. I sometimes give my students the instance of meningitis; when there was no treatment for meningitis it was only really your own reputation that suffered if you did not make the

diagnosis early or did not make it at all, but now it means the difference between life and death; so that that is an increased responsibility, for example.

1668. What you are really saying is that the general practitioner has to have more knowledge in order to make the correct diagnosis?—And to apply the remedy, if it is a case in which the remedy is in his hands. If it is not, then his remedy is to seek the aid of someone who can apply it. I have no doubt at all about the responsibility.

1669. *Professor Jewkes*: This is really another aspect of this very heartening phrase you used a minute ago, the renaissance of general practitioners.—Yes.

1670. *Chairman*: Having more responsibility he has also got rather more means at his disposal with which to do some of these things, so long as he knows how to use them. But he must know how.—This applies to all branches too. My own work is far more complicated than the work of a physician when I qualified.

1671. It applies to a great many occupations—the increasing technicality of life in this period of modern invention.—*Sir Harold Boldero*: May I add a thought here? Of course it is true there is increased responsibility, but it is equally true, particularly in the rural areas, that general practitioners have more facilities for getting consultants' opinion than they had before.—*Dr. Platt*: That makes a very big change, which the Health Service had a lot to do in bringing about.

1672. *Sir Hugh Watson*: That must tend in some measure to lessen the load of responsibility on the general practitioner, if he knows he has at his hand, as *Sir Harold* has said, a consultant; provided he knows which consultant to go to.—Yes, I do not think it acts in the sense of reducing responsibility. There is no doubt at all in my mind that the responsibility has increased.

1673. In general practice?—For doctors at all levels.

1674. We have been told, *Dr. Platt*, that under modern conditions doctors tend to refer more cases to hospitals and to send them into hospitals?—Yes.

1675. That means when they go into hospital, unless it is a cottage hospital, the general practitioner no longer has

responsibility for the patients, is that right?—Our out-patient departments nowadays in hospitals do not take on the treatment of a patient; they are consultative departments. The patient is sent to see a physician, the necessary investigations are done, and a report is sent to the general practitioner who is then responsible for the further treatment of that patient. It may, of course, be more complex than that—the patient may have to go into hospital for investigation, treatment and an operation, and so on, and it may be weeks before the general practitioner sees that patient again. Everything may be over by then, but in a very large number of cases the hospital doctor simply acts in the rôle of consultant.

1676. *Sir David Hughes Parry*: And thereby diminishes to some extent the responsibility of the general practitioner for diagnosis?—Yes, for the time being. The general practitioner passes on the responsibility but it comes back to him.

1677. *Mr. Gunlake*: I wonder how far one needs to pursue the question of responsibility, which affects all of us in all walks of life. I think what we are really concerned about, are we not, is whether there has been an increase in the strain of responsibility? We all have increased responsibilities but the point is, is it more of a burden and a strain on the general practitioner and the consultant?—I would say, yes. I think the responsibilities have increased—for example, in this instance I have given you where your action makes so much more difference than it used to.

1678. Of course, with increasing medical progress the strain must go on increasing and must come to the point when it would become insupportable.—I suppose the answer to that is that you would have to have more doctors then, would you not, so that you would have fewer patients to treat; then it would become supportable again.—*Sir Russell Brain*: There is also the correct use of the very complicated modern apparatus for investigation which often carries its own risks. The correct use of powerful drugs and radio-active substances, used now more than ever before and which carry their own risks if not properly used. I think those other aspects of the responsibility of dealing with every patient have very noticeably

increased during the time I have been in practice.

Mr. Guntlake: Yes. But if I may venture to say so, the strain of responsibility is something that up to a point one can get used to.

1679. *Sir Hugh Watson:* Would you say, Dr. Platt, that the fact that of recent times more prominence has been given to legal liability on the part of doctors has caused them anxiety?—*Dr. Platt:* Yes, I think it has caused anxiety in a number of quarters, particularly, I think, with people who have anything to do with the treatment of accidents, and so on, but also in hospital work and general practice. Litigation has increased enormously really, has it not?

1680. I did not mean that. What I really meant was this: as you know, there have been a number of cases in the last ten years or so where doctors in various capacities, both general practitioner and hospital doctors, have been sued for negligence?—Yes.

1681. Is that a matter which causes the doctors anxiety?—That is what I meant—that the amount of litigation on the part of patients has increased.

1682. Against doctors?—Yes. I think it worries some people quite a lot. I do not say all, I do not think most of us lie awake at night thinking about it!

1683. I hope not! Now, on page 324—May I just mention this; we have rather passed over this question of the training of consultants, or does that come in later?

Sir Hugh Watson: If you want to take it now, please do.

1684. *Chairman:* Do you mean the part on page 323 where you say that those who hope to become consultants must settle down to at least five years post-graduate training and often far more?—Yes. We do think this is a very important thing. This is why we still think there must be a differential kept up between the pay of consultants in general and practitioners in general. At least, that is one of the reasons. Seven years, I suppose, is the minimum post-graduate training. At present conditions are bad and the people are not getting consultant jobs until they are thirty-five or forty, and that was never intended. Even if they get them between

thirty and thirty-five, which we think is very right, they have probably qualified at twenty-four and have done 10 years work. Two years of that may have been in the Army but they have done at least eight years training before they become consultants at all and at every stage of this training there is competition. You select, usually, best men of the year to be the house men in the teaching hospital. These people have to take difficult higher examinations. They compete for posts as registrars and senior registrars and so on.

1685. *Sir Hugh Watson:* And you would welcome that competition?—Yes, so long as it is fair competition and you have not got to a stage where you are training far more men than there are posts for.

1686. Shall we deal with that subject now, Dr. Platt, it might come in quite appropriately here? We are aware that there are a very large number of registrars, senior registrars and senior hospital medical officers at the moment who find it very difficult to achieve the next step and become consultants. We are told, in point of fact, that many of them have to wait until they are forty years old and the expression was even used the other day that "some of them drop off the ladder". To some extent, am I right in thinking that this is a temporary situation?—Yes, it is, but it is a very serious one at the present time.

1687. Is it sufficiently appreciated that it is temporary?—It is a temporary situation that has been going on for a very long time. We think that there is room for more consultant posts, and that if they were created then these young men, or these ageing men, would get a chance. After all, they are fully trained and responsible people and they are quite ready to step into a consultant post. I might say that Sir Russell Brain knows personally of many cases where they have emigrated. We are compiling some evidence on emigration but it will not apply purely to this type of person, it will be emigration in general. I do not know to what extent it is the business of your Commission but I would like you to take note of this situation if you can because I think it is causing a great deal of anxiety and discontent. I think really the Service is exploiting these men.

1688. You suggested that the number of consultants should be increased and then many of these gentlemen would be able to get posts?—Yes.

1689. In your view does the public service require more consultants?—Yes.

1690. This is rather puzzling us, you see, because we are told that many of these senior registrars work without supervision and are in fact doing work that ought to be done by consultants. It is rather puzzling us to know just exactly how all this works and how you think it ought to work.—I think that there is room for more consultants, undoubtedly. I think the need is probably greater in the non-teaching than in the teaching hospitals.

1691. *Sir David Hughes Parry*: I wonder whether we can take it along these lines: a man will qualify, normally, at the age of about twenty-four, is that right?—Yes.

1692. He will probably have done two years National Service, many of them may have done three years, so that makes him twenty-six.—I should have thought very few did three years, I have not heard of any myself.

1693. I know of a number who have. So that the average age then would be about twenty-six and then they would find some difficulty in getting into a post?—But, first of all, they have done a compulsory year in hospital before going into the Service at all.

1694. So that would make them older still?—Yes, twenty-seven.

1695. They are twenty-seven then. Now, you suggest that they should be appointed as consultants at about thirty, thirty-one or thirty-two. The average age is going to be thirty-two, so some of them must be appointed under thirty-two.—What I think I said was, thirty to thirty-five.

1696. Yes.—And what I think the Spens Committee had in mind was thirty-two.

1697. Yes, an average age of thirty-two.—But was the Spens Committee expecting that for a definite period everybody would do two years military service? I do not think they were.

1698. They are doing it, and what you are saying is that they are ageing before they are now appointed to consultant posts. So two years ought to be added to the Spens age?—Perhaps so. They do not all do military service, of course, for various reasons.

1699. I appreciate that.—I know one very clever man who was in my department and who was appointed a consultant at the age of thirty-one. He was one of those who did not have to do military service.

1700. The layman is inclined to look upon the consultant as a wise man of very considerable experience and he would tend to regard your brilliant young man as more of a specialist than a consultant. I wonder whether there is not room for that intermediate grade? I find it very hard to picture a young person being a consultant—wise, mature, knowledgeable at thirty-one, or thirty-two. Ought not the training at that stage to be much longer?—No, I think this is solely a question of definition. I think some people are very wise at thirty, thirty-one or thirty-two, and I think if you are going to try and create another level in between consultants and senior registrars you are going to create a lot more discontent—unless you are going to say that there is sometimes room for a man to be an assistant, but if so he is to have the full privileges of a consultant. He may be a junior member of the team in the hospital but with the full privileges and responsibilities of the consultant and with the automatic right of succession, when his time comes, to the senior post. I think that would be acceptable but I think to create just another grade would be a bad thing.

1701. *Chairman*: I also thought you were saying, Dr. Platt, that you do not want consultant posts created just to help people out of difficulties because they are stuck in the registrar grades. You want consultant posts created where consultant posts are needed?—Yes. In other words, I think a number of hospitals are not fully covered for their consultant service at the present time.

1702. Is there a big deficiency, do you think?—No, I would not say that it was a very big deficiency but I have no figures for this because no survey has been done. Of course, we have been urging the Ministry to make a survey

of this kind for a long time, but without success.

1703. And it varies from specialty to specialty. I suppose?—Very much. We know there are some specialties in which a man can get a job tomorrow if he is ready and trained. They are crying out for them.

1704. *Mr. Gwylake*: Has the Ministry given any reasons for resisting this survey?—I think I will put this awkward question to Sir Russell, because he has been so much at the spearhead of this.—*Sir Russell Brain*: I am not used to being an interpreter of the Ministry!

1705. I only asked if they had given any reason or if they had simply said, no.—I think the main reason is that they think it would not serve a useful purpose, or it would be a difficult time-consuming job to carry out compared with any value which would be likely to emerge from it.

1706. *Chairman*: Can you just tell us the technique of establishing a new consultancy, as it were? How is it decided that there ought to be another consultant post?—Normally, the Regional Board or teaching hospital comes to that conclusion, probably on the advice of the Medical Committee. It then applies to the Ministry and the Ministry has a small committee on which the Joint Consultants' Committee is represented; they have their own advisers, and that committee goes into the question. Sir Harold really knows more about this than I do because he has served on that Committee, but that is broadly what happens. And then they approve or disapprove, as the case may be. There is, of course, still the fundamental question at Regional Board level of being able to afford a new consultant in competition with other financial claims.

1707. In fact, there has been a fairly steady increase in the number of consultants since the Health Service came into being, starting with a very big increase early on and then going on more steadily and gradually since, is that not broadly right?—*Dr. Platt*: That is quite true. There was a very big increase in the early years of the Service. A lot of new posts were being created and it was that, really, that led to the training of a lot of people. Then rather suddenly it became the case that there were not

enough jobs for them, they were all filled.

1708. *Sir David Hughes Parry*: There was a good deal of upgrading at that time, was there not, of people in the full-time hospital service?—Yes.

1709. *Chairman*: But it is quite clear that you do not think anybody should be entitled to become a consultant because they have passed the examinations, but that there should be competition in that sense for the posts that are needed to fill the needs of the Service.—Yes, I think that is right.—*Sir Harold Boldero*: I am so glad you made that clear. I agree with what Sir Russell said in answer to a question, but the committee at the Ministry of Health, with doctors from outside sitting on it, only concern themselves with posts. They would only, therefore, approve or disapprove of a new post. That post then goes back to the body that asked for it, the Regional Board or the Board of Governors at a teaching hospital, and it is advertised openly and publicly and applicants are then appointed, again by the body that asked for the post.

1710. *Professor Jewkes*: Could I ask one more question about this total number of consultants? If there is a shortage of consultant posts, as you suggest, one would expect to find that the Medical Committees at the Regional Board level, and the Medical Committee at the higher level would agitate all the time for more consultant posts. But are they doing that? We know, Sir Russell, that above us are the people who decide what finance can be allocated but the initiative for more consultant posts would have to come from the profession itself. Is that happening?—*Dr. Platt*: I do not think it is happening as much as it should do but I think that is largely because everybody is damped down by the question of budgets. We have heard nothing but: "We cannot afford it", for a long time.

1711. But if doctors think there should be more consultants, they should say that and leave other things aside.—Yes.

1712. If the number was increased up to the point you thought reasonable, do you think this would deal with the problem of the senior registrar?—Yes.

1713. It should be sufficient to deal with it?—Yes. I mean, I am not saying that a certain number of individual problems will not always exist in any state of affairs but it would deal with the immediate and very serious problem at this stage.—*Sir Russell Brain*: And provided, if I might add, that the number of senior registrars in future was kept within such a relationship that they could reasonably expect to become consultants.

Sir David Hughes Parry: There would have to be a fixed ascertained relationship between the number of posts of senior registrar and vacancies in the consultant grade.

1714. *Professor Jewkes*: Does it mean, Dr. Platt, that the real problem here is the shortage of consultants and not the surplus of senior registrars? If there is a shortage of consultants it is something that the community is lacking but the surplus of senior registrars, serious as it is, only affects a handful of people.—*Dr. Platt*: Yes.

1715. And you would deal with the minor problem by dealing with the major problem?—It has very important repercussions on contentment and recruitment. You see, the bright young men whom we would like to see at the present time training and getting up to the senior registrar jobs and consultant jobs are hesitating to go into consultancy at all at present because they can see this hold-up. They cannot see any immediate prospects and it has a lot of repercussions. It is not just hardship for a little bunch of men.

1716. But the shortage of consultants has even more serious repercussions, has it not, on the community in the sense that if we are short of consultants the waiting lists must be increasing or patients must be suffering who need not suffer, or people may be dying who might have been kept alive? That is what a consultant shortage means?—It is always very difficult to estimate.

Professor Jewkes: Yes, I know.

1717. *Chairman*: I want to come back to this question you raised, Dr. Platt, about training. I think you said that one reason why the consultant must always be relatively highly paid is because of the length of additional post-graduate

training. Is that right?—Yes, and because he does succeed through a series of competitions.

1718. Yes, I was going to take both points.—There are some other reasons which we will probably come on to.

1719. I was just going to ask this on the question of the long period of post-graduate training. The trainee is, of course, earning during most of that period, is he not?—Yes.

1720. On the whole, is he earning at a lower level in those early years than if he had gone into the general practice branch of the profession? It is probably hard to say that.—I would say undoubtedly after the first few years. During the first few years, I suppose, a trainee in general practice is not getting a very big amount. But after the first few years when he is a man of thirty to thirty-five, the senior registrar, I should say unquestionably, is getting less than he would get as a general practitioner.

1721. We are talking of the man who commonly becomes a consultant at thirty to thirty-five. Would you say as an average—even if you take it at the top age of thirty-five—you are covering a period of six or seven years during part of which he will be earning less than the more successful of his opposite numbers in the other branch of the profession? Is that right?—Yes, I think that is undoubtedly true.

1722. And that you would feel if he is earning less at one stage of his career it requires compensation at a later stage if there is to be an attraction to go into that branch?—Yes, but I think that is only one of the points.

1723. *Sir Hugh Watson*: That is a very large subject. As you know, Dr. Platt, what the Spens Committee had in mind was that they wanted to give to the consultants a security in the early stages which was severely lacking before the National Health Service.—Yes.

1724. And to some extent they have achieved that because a consultant without a merit award at the age of thirty receives £1,890 a year, and a consultant who goes through the stages of the normal remuneration, again without a merit award, 8 years later receives £3,255. These figures are gross before tax.—Yes.

1725. The average general practitioner earns £2,222—if the average general practitioner exists!—You were saying if he enters at thirty but, of course, very few do enter at thirty, and actually those are figures for whole-time work. Most young consultants will not be appointed to whole-time posts; they will be appointed to part-time posts with something like seven, eight or nine sessions for which remuneration is only proportional. And, of course, in their early years private practice will be very small, although they may incur considerable expenses in keeping premises and employing secretarial help, and so on.

1726. We are now off on to another subject again, because this is a very wide subject. We are on the difference between part-time and whole-time consultants which I would prefer, if you do not mind, to leave for a little while. —Yes.

1727. 70 per cent. of consultants are maximum part-timers, are they not, doing nine sessions and paid for nine and half?—I do not know, but I believe those are the figures you have ascertained.

1728. I got them from Sir Russell Brain the other day, actually, and again from Sir Russell I obtained the information that most of the consultants averaged seven or eight sessions. I know that is taking it over the whole field. There is this difficulty about consultants, is there not, that the bottleneck which we have been discussing occurs in the major specialties—general medicine, general surgery, gynaecology and obstetrics?—Yes, those are the worst.

1729. Can you tell us why the people who are progressing up the registrar and senior registrar ladder, who are aware of the difficulties of getting into these specialties, do not seek an outlet in the other specialties which, you told us a moment ago, they can get into almost at any time?—Yes, but the training would be different. I mean, to take an extreme case, you cannot suddenly decide to become a surgeon when your training for the last five years has been that of a physician. Even to take more related branches like psychiatry, which is short of consultants, (1) you cannot just change your training like that and (2) there are only a certain number of people who want to spend their lives in

psychiatry. It is a very special branch of the profession for which you have to feel that you have a considerable aptitude, I think. I have often talked to young men and said: "Your chance, you know, of getting on would be better in psychiatry, pathology or paediatrics", but they say: "I just do not want to do those things".

1730. That would seem to indicate that financial remuneration is not everything to these doctors!—I am quite sure it is not everything. I am sure it is not the chief incentive of the medical profession at all.—*Sir Russell Brain*: Could I make one comment on what you said? Many younger consultants when they start do not begin with seven or eight sessions, quite a few of them only have three or four and may have to wait to add to those; and then they have real hardship. If you translate what they are earning under their present rates in terms of what it was worth in 1939 I think it is pretty evident that Spens' ambitions have not been achieved.

1731. Supposing, as you say, Sir Russell, and I know you are right, they start with three or four sessions. Apart from that they have what private practice they can find, have they?—Yes. I think it is the increasing tendency to try perhaps to carry seven or eight sessions for that reason, but I know that there are quite a few who on starting have not more than three or four and who may actually be worse off than they were as senior registrars.

1732. *Chairman*: When a consultant dies or retires presumably his post is completely filled by another consultant? If he was doing nine sessions, for instance, in, say, two hospitals within the same area, the vacancy will not be filled by two people each of whom are going to do four sessions. It is more likely to be filled by one person covering that same area, is it not?—Not necessarily. They are individual posts at individual hospitals and, therefore, they would be advertised separately and it might happen that one of those posts would be filled by additional sessions going to somebody else working at that hospital.

1733. I wonder what really does happen normally?—I would think commonly they would be advertised separately unless they involved a single

appointment with visits to different hospitals. But if there were several different hospital appointments they might be divided up.

1734. Perhaps I can come to another point. If a new consultant post is created because need is shown is it ever as little as two or three-elevenths of a week that is created or is it usually shown that there is need for one full new consultant, say, nine-elevenths?—*Sir Harold Boldero*: A new one is very seldom advertised for so few as two or three sessions as you said. Nearly always it is in the higher brackets—seven, eight or nine—because the hospital has failed to get applicants for a smaller number.

1735. But in fact a new post created is usually over half?—Yes. May I add one other point to what *Sir Russell* was saying about when a vacancy occurs owing to retirement at sixty-five. It is automatically filled under the same conditions. There is one other aspect; the Service has only been going for ten years and Regional Boards and Boards of Governors in seeking to make rearrangements or improvements in the Service have sometimes had to wait, rather than compel a man to do this or that, until a vacancy occurs; they seize the opportunity of a vacancy to readjust the work. This is a subsidiary reason to explain why vacancies are not all advertised and filled under exactly the same conditions.

1736. I wonder if you would be able to give us any figures, or perhaps the Ministry can, of the extent to which these younger consultants get their first few posts? Do they in fact start off with a total of three, four, or five sessions and get up as quickly as they can to nine or eleven? Those are figures that as far as I know we have not received.—*Sir Russell Brain*: I do not think we have them.

1737. We may be able to get some figures from the Ministry perhaps of those who have become consultants over the last few years and whether in fact they have been getting a few sessions and have had to fill in their time elsewhere against their will, or whether in fact it is a rarity.—I think it is a diminishing number because the problem has been realised. As *Sir Harold* said there is a tendency to advertise the larger number of sessions. Of

course, that sets up another problem altogether involving the number of sessions at a group of hospitals which again can only be overcome by limiting the sessions at a particular hospital to two.

1738. We were really on *Sir Hugh Watson's* point as to whether in fact the young man, when he becomes a consultant, is really getting something which very quickly gets to the average level of the general practitioner and passes it by about the third year, or whether because he is not anything like a full-time consultant and is not able to fill in his time profitably outside it is many more years before he catches up. That, I think *Sir Hugh*, is what you were getting at.—A sample investigation should throw some light on that.

1739. *Sir Hugh Watson*: I thought when I came here this morning I had tied everything up into neat compartments but we cannot help flowing into one or the other. Perhaps you can help me. On the last occasion when the Joint Consultants' Committee was giving evidence we were told that the Ministry had accepted the principle that when a man applied for a consultant post he was appointed a consultant; but it was not until after he had accepted the post that the Ministry said: "Do you want to be whole-time or part-time?" To what state of affairs does that relate?—That could only apply to positions which involved whole-time or maximum part-time sessions. It could not apply, obviously, to the small number of sessions.

1740. *Professor Jewkes*: May I ask one question which is a little aside from this but connected to the promotion to the consultant class? You mentioned that it is more difficult now for the registrar who either does not wish to go on, or cannot go on, to get back into general practice. Why is that so?—*Dr. Platt*: I do not know why that is, really. It seems to be more difficult to go into general practice altogether. I suppose one thing is that committees appoint doctors now whereas before, of course, you could buy a practice. It was easier then provided you could get the money. There is, I think, another reason, rather more important, that the two branches of Medicine have diverged a good deal, and what we do in hospitals now many general practitioners would consider to be not such a good training

for general practice as it was 30 years ago when there was less hospital treatment. I think that is only partially true, of course. I think it is a very good thing for a young man to do more than the minimum one year in hospital—very good, whatever experience you have—but when you get a man who has been in a rather specialised branch of Medicine such as cardiology or neurology for four or five years, the general practitioners rather look askance at him and think he is rather too much of a specialist.

1741. So it does tend to increase the risk of a young man who steps up the ladder towards consultancy?—Unquestionably, yes.

1742. *Sir David Hughes Parry*: But you would agree that the right time for the man to make a final decision is after he becomes an ordinary registrar and before he goes up to the senior registrar position?—I think that is true and I also think that it is the duty of his seniors, and so on, to keep a very close eye on the senior registrar in his early years. If we do not think he is going to be a success we should try and divert him into some other channel before he has done years of training.

1743. And it is not really the question of remuneration that causes discontent in the senior registrar grade but the uncertainty of whether they are going to be appointed as consultants?—Well, it is both, you know, because these men are getting older. So many of them have young families growing up and their remuneration is not very high.

1744. One would wonder whether it might not be advisable to prolong the ladder of the senior registrar scale and certainly in that period.—As a temporary solution to the problem, of course, we have urged that they should have an incremental salary while they are waiting for a post.

1745. *Chairman*: Coming back to that question of whether a consultant usually starts with three or four sessions, or some small number, there is a table facing page 90 of the Ministry's Factual Memorandum which shows that with those born since 1918 the enormous majority appear to be on nine or 11 sessions, judging by the total number of sessions and total number of persons. I

think that would show that all the comparatively young ones, who are presumably those who have become consultants recently, in most cases have got 8, 9 or 11 sessions.—I would say that it is usual nowadays to have seven or more sessions but I agree with Sir Russell that there have been some notable exceptions, especially in teaching hospitals which have often favoured a rather lower number of sessions.

1746. *Sir Hugh Watson*: Coming back for a moment to Sir David Hughes Parry's last point: do you think it would be a good thing if arrangements could be made for an easier transfer from the hospital service, in the early stages of a doctor's career, to general practice?—Yes.

1747. You mentioned a moment ago that you thought there was a great advantage to be derived for the general practitioner to do more than the compulsory period in hospital?—Yes.

1748. In the first place, we are given to understand, as you said a moment ago, that a young specialist is not welcome in general practice.—Yes.

1749. Secondly, it is difficult for registrars to get out into general practice if for any reason they find they prefer it or are not suited to go on up the ladder. Do you think it would be a good thing if that could be done?—Yes, I do and I think that future developments in general practice will tend towards group practice. That should make it easier because in a group you should welcome a man who has got, say, at least a bit of training in some special branch of Medicine.

1750. We have had instances of practices where among four partners three were specialists in one thing or another.—Yes.

1751. *Chairman*: Would you say that was a good thing?—Yes.

1752. *Professor Jewkes*: Are there any other ways in which you might make it easier to transfer from the consultants' ladder to general practice?—I cannot think of them just at the moment. There may be some.

1753. *Mr. McIntosh*: Would you be in favour of extending the compulsory period of service in hospital for all doctors?—No, I do not think so.

1754. That might possibly be a way of increasing the period of specialisation, so to speak, for everybody.—Yes, but I am not in favour of too much compulsion. That is what makes me say no. I think that the majority of young men are quite well advised to spend more than the minimum year in hospital but I do not think I would like it to be compulsory.

1755. *Sir Hugh Watson*: Can you tell us whether in point of fact young doctors who are going into general practice do spend more than the compulsory year in hospital?—I should think many of them do. I am not sure if *Sir Russell Brain*: I was just looking at it. I happened to look at ophthalmology where you will see that since 1919, roughly, you have six sessions, five sessions, and four sessions. I do not know if there is any special reason for that but there seems . . .

1756. There are certain specialties which seem to have quite a different experience to the other larger ones but in most of them that is rather contrary to the general picture.—I quite agree, they are exceptions.

Chairman: I think this would be a convenient point at which to adjourn.

(The proceedings were adjourned for lunch.)

On resumption.

1757. *Sir Hugh Watson*: There is one matter I would like to explore with you if I may, in which I was heavily shot down a fortnight ago, but I think it is worth pursuing. That is this question of an intermediate grade which we discussed this morning.—*Dr. Platt*: Yes.

1758. This question was rather puzzling the Commission. We quite appreciate that the registrar grade is to some extent at least a training grade, but to some extent at least it is also an operative grade, is it not?—Yes.

1759. Now I suppose also with registrars, part of their work is educational?—You mean educational for themselves?

1760. No.—They are teaching?

1761. Yes.—Yes, in a teaching hospital they are.

1762. I suppose a good deal of their work is done not under supervision?—That is not a question you can answer just Yes or No. My senior registrar will see a number of out-patients who are referred to my unit from doctors. I cannot see them all myself. He will see them, he will examine them, write letters, deal with them completely. All right, he is not under supervision; but if he is in the slightest doubt I and other senior colleagues are there, and he can get hold of us at any time. Also he is working as one of the team, and he knows the ways the team deal with certain problems which are likely to be presented, so he is really not working in isolation even though he is not supervised the whole time.

1763. Do I understand the position correctly that the moment a senior registrar becomes a consultant he has then reached independence?—Yes.

1764. And he no longer requires supervision at all?—Yes.

1765. This point has been pressed by two of the Scottish Colleges, *Dr. Platt*, that a method of dealing with this bottleneck would be to introduce this intermediate grade—the senior assistant physician and the senior assistant surgeon—in the hospital. It has been suggested, for instance, that a grade might be evolved which would supersede both the S.H.M.O. and senior registrar, and be paid on a scale which at its top end would overlap the lower ranges of the consultant scale. You would then have a situation where people would know that at the worst they would be paid the top of that scale.—Yes.

1766. And that at the best they could work through into the consultant ranks.—Yes.

1767. What would your view be about that?—I think it is a bad solution. Financially it may be a helpful solution, but I think it is a bad one. I think a senior registrar is a man who, in the first place, has been picked for the job, and in the second place he should have been watched very carefully in his early years during training to be a consultant. He has reached the stage when he is perfectly able to take on responsibility on his own account. I do not really see why he should then need to go through some period of being in a subordinate position any longer.

1768. The thing that I was contemplating would not I would hope be regarded as a subordinate position. It would not be consultant position, but it would be something higher than a senior registrar.—Yes, I think it is still a subordinate position, is it not, really?

1769. I suppose it would be a subordinate position. You would not achieve the consultant position.—Yes, and I think the next thing would be that certain rather bright young men would get ahead of him and leapfrog him, would they not, unless your grade is automatically going to lead to his being consultant?

1770. Oh no, it would not lead automatically. I would visualise no one could become a consultant without passing through it, but it would not necessarily automatically lead to a consultant post. Anyone in the grade who was not promoted consultant I would suppose would remain in that job with the appropriate extended salary scale.—Yes. I think it is unfair because I think it just does not give the man responsibility which he is perfectly able to take.

1771. *Chairman*: You have not visualised everybody who goes on that side of the profession will automatically become a consultant eventually?—No.

1772. You feel that there will be some people who would stay well short of that, but they would stay at a considerably lower salary?—I think those are people who will fail to make the grade, and will finally give it up and go on to something else. I think in any set-up of this kind there are bound to be some who do not succeed. I do not think it can be automatic entry.

1773. We discussed this question the other day and Sir David Hughes Parry had quite a discussion with Sir Russell Brain and some of his colleagues on the question of wastage on the way up the ladder.—Yes.

1774. And Sir David was rather pressing the point against Sir Russell Brain and his colleagues that he would expect there would be a quite appreciable wastage even from the senior registrar class. But I gather that is not so in your view?—No, I do not think it should be very big. I believe the analogy was made with professors and lecturers.

1775. *Sir David Hughes Parry*: Yes.—And I think that is a different state of affairs altogether. I think a man who goes into a University post is interested in teaching and research and other things, quite apart from the practice of his profession. The people we are discussing are interested primarily in the practice of their profession and the management and treatment of patients. They reach the stage where they want to do this, and accept full responsibility. They are not really fully grown personalities until they do.

1776. You do not consider they could do that, that they could be satisfied they were doing that in anything short of full consultant status?—I do not consider that they can, no, not satisfactorily. I think in certain hospitals it may be, in fact it often was the case before the Health Service that they were organised with two physicians in a unit, or two surgeons; one was the senior, and the other was sometimes called the assistant surgeon. But it was automatic, or almost automatic, that the assistant went up to the next senior post which was offered, and he was really practically of equal status. He had his own beds allotted to him out of the unit, and he really was an independent person.

1777. *Chairman*: You would feel in a sense, would you, that the consultants as a whole are the basic grade of consultant, but there is a grade above it represented by the merit award system?—Yes, precisely.

1778. And that this particular problem, Dr. Platt, was never really quite covered by Spens. Spens' point was on the equality of status between the different branches of specialist practice rather than between different specialists within the same specialty. Is not that really it?—Yes.

1779. Do you know if it was just not considered at all, and if so why?—I thought that the Spens answer to the problem of status within a specialty was really the merit award.

1780. Yes.—*Sir Russell Brain*: Perhaps I could add, and I have spoken about this before, we do not see any criterion in the difference of function, any practical difference of function within the consultant grade which would justify this kind of discrimination. It

might be attractive from the point of view of saving money, or in some hierarchical system which had justification in past practice where it exists, but we cannot see that the duties of a man once he becomes consultant and has responsibilities are in any way different from those of a more senior consultant in the service.

1781. *Sir David Hughes Parry*: I wonder if I could put it in this form, that there is an interim period between the registrar becoming a consultant, and it is a period of anxiety and uncertainty for the person who is in that position? Since Spens' time that period has been rather extended, and I am wondering whether there is not room for a further extension of the period, with promotions, with an increase in salary regularly up to an approved age, having regard to the fact that the training period is much longer and inevitably must continue to be so with the increase of knowledge and techniques. One wonders whether this ought not to be recognised as a slightly more extended period and that there should be a longer period of salary increments in recognition of it. That is the proposition I think that we have had.—*Dr. Platt*: I think our answer is that the period should not exist really, and that it only exists because of this present hold-up in the structure.

1782. We have been led to understand that reaching consultant status is a very high honour and privilege in the profession. It may be that we think that it would be watering down, if I may use that expression, the consultant grade if the promotion of the senior registrar into that grade was ensured almost as a matter of course.—A young man properly trained should be able to take responsibility after sixteen years of training—I mean counting their period as medical students—and it is quite a long time. I do not think you want to extend it by another five years. That is my answer.

1783. *Professor Jewkes*: If these are your views, it is clearly of the greatest importance that the number of senior registrars should be controlled in some way.—Yes.

1784. So that you do not have a surplus.—Certainly.

1785. Once you fix the right number of consultants you have to have a corresponding number of senior registrars. But, after all, we have run into this trouble once and we are confronted with the consequences of it now. How would you propose to avoid it again?—I think the plans are fairly well made for this as far as I know. I do not know if *Sir Harold* knows about them, but it has been worked out pretty well.—*Sir Harold Boldero*: I think the short answer is that some years ago a number, a total number of senior registrar posts for this country, was decided upon. It had a direct relationship to the number of consultant vacancies and the expected number of consultant vacancies. For probably administrative reasons, and the numbers left over from the war, the number of senior registrars never got down to this theoretically desirable figure. We hope that when this present bulge, if I may so describe it, of too many senior registrars is overcome, a number, not necessarily the old one, will be adhered to strictly. I would add one other thing. My own view is that I do not think necessarily one hundred per cent. of those who go through their first year as senior registrars should ultimately become consultants. They are open to annual appointment, and if they are not sufficiently promising their appointment should be terminated after the first or second year, preferably not so late as the second.

1786. Where do they go if they fall out in this way, even the few cases? Do they go into general practice?—There are several possibilities. The obvious one is general practice. We were talking about the difficulties of doing that only this morning. There are still Colonial medical services.

1787. *Chairman*: Is the senior registrar the right stage for recruitment in the Colonial services?—At one time, Sir, I would not say this year, but at one time the Colonial Office were very definitely looking for this very kind of man.

1788. I suppose that in fact there have probably been more than the normal number of accepted vacancies for consultants in recent years, if you add together both the actual vacancies occurring because of death and retirement, and

the new consultancies that have been created by adding to the total number year after year?—*Dr. Platt*: There have been more consultant posts created. That at the same time created this apparent need for training more people. All those posts have now been filled, and they have mostly been filled with people who were on appointment, perhaps between 35 and 40. Therefore it is going to be rather a long time before there is any sudden glut of consultant appointments in the country.

1789. There has been every year an increase I think in the number of consultant posts over the previous year.—*Yes*, but I do not think that that increase has been very great in general medicine and surgery in the last year or two. I speak subject to the figures, but I think you will find that is correct.

1790. I suppose you would take it you would remain a consultant for pretty well thirty years, and you have to relate the number of senior registrar posts for four years to the number of consultancies lasting for thirty years, is that it?—*Yes*.

1791. You will always be in danger of having this difficulty, and you cannot always find the way out by heading for the right number of consultancies in order to relieve, or partly in order to relieve pressure.—*Sir Russell Brain*: I am not quite sure that one should always be in danger if the number is properly adjusted. Naturally if there is a miscalculation again we should be in the same position, but if, so to speak, a proper actuarial estimate of consultant vacancies is made and you do not have more registrars than can fill posts then it should work satisfactorily.

1792. How many senior registrars ought there to be if there are, say, 7,000 consultants?—If they did four or five years in relation to thirty I suppose it would be a sixth.

1793. About one thousand?—*Yes*.

1794. And could the service be manned efficiently with as many as 7,000 consultants, and as few as a thousand senior registrars?—*We think it could*, and part of the answer in our view is that the younger consultants should be encouraged to do more of the emergency work, and that kind of thing, which is now being done to some extent by registrars.

1795. *Sir Hugh Watson*: Sir Harold mentioned the bulge. Would you expect, Sir Harold, when the bulge works itself out things might be much more what you would regard as normal?—*Sir Harold Boldero*: If the number of posts for senior registrars was effectively controlled.

1796. You explained to us very clearly that at the inception of the Health Service an ideal number of registrars was fixed.—*No*, Sir.

1797. I thought you had said that?—*I am sorry*, I did not mean to convey that. At the inception Boards of Governors and Regional Hospital Boards were free to make locally the number of registrars and senior registrars that they desired. I think one of the difficulties was that it was not until some years after the inception that it was realised that central control of the number of senior registrars was desirable. One of the reasons it never got down to the desirable number was there were too many men already in post.

1798. The position was aggravated by the return of men from the armed forces?—*Yes*.

1799. Have you any idea when that bulge will work itself out?—*If I knew* when a solution was to be applied I could answer, but at the moment the bulge is being kept on from year to year, and I do not know how long it will take if nothing is done. If something effective is done it could work itself out in a year or two.—*Sir Russell Brain*: There is one other point, and that is that some of the work now done by senior registrars could, if there were fewer of them, be done equally well by registrars who would be glad to have the experience for a year or two.

1800. I think that follows from the point that the Chairman made a moment ago. The question he asked in effect was this: is the number of registrars that you visualise as being appropriate to fill the consultant vacancies which are coming ahead, adequate to staff the hospitals at the same time? Do these things by some miracle coincide?—*Sir Russell Brain*: This is one of the answers.—*Dr. Platt*: One of the answers is that some of the work can be done by people of registrar status and not senior registrar.

1801. *Professor Jewkes*: On this question of supply, if we just go down one stage lower in the hierarchy, one or two witnesses have suggested to us that there is a shortage of registrars developing.—Yes.

1802. Does this mean we have at the registrar level a shortage, at the senior registrar level a surplus, and at the consultant level again a shortage? Is that the picture?—I think that is true.

1803. Why is the shortage in registrars developing?—One answer is because they have seen what happens to senior registrars.

1804. *Chairman*: Dr. Platt, is that shortage in both the teaching hospitals and the peripheral ones, or mainly at the periphery?—As far as my information goes entirely in the peripheral hospitals, not in the teaching hospitals.

1805. And that leads to a further point, of course. Ought there to be some means of ensuring that the peripheral hospitals are equally attractive in one way or another?—Yes.

1806. Have you any suggestions to make about that?—It is very difficult I think to find adequate means of ensuring that. Men will naturally always prefer to go where the main teaching centres are for periods of their training. I do not think that making the money better is a very good thing. I do not think it really makes a lot of difference, unless you made it a very big one, which I think would be unwise. We have suggested in a tentative way that in some peripheral hospitals conditions might be improved. Junior medical staff might, for instance, be given married quarters if they are young married men, and that kind of thing, but otherwise I think it is very difficult to find the right answer.

1807. It is going to be an increasingly important matter, is it not, to make sure that the peripheral hospitals are going to be properly staffed?—Yes. It would, of course, help enormously if it became accepted that it was a good thing to do this kind of work before going into general practice; if in the development of group practice practitioners came to prefer this kind of man it would make a lot of difference to recruitment and it would be generally easier to get into general practice than it is today.

1808. *Sir Hugh Watson*: This question of shortage, Dr. Platt, is very closely allied to recruitment. You rather express the fear on page 326 of your memorandum of qualitative deterioration, as you call it, and you say it is very much in your minds. Have you any evidence that it has set in?—This was in relation to entrants to the profession?

1809. Yes.—I think it is fair to say we have no evidence. We have questioned a number of Deans of Medical Schools, but they can really only give us impressions. Some of them think the quality has dropped; most of them would not say so. But this again, I think, is one of these very long term things, is it not? If the profession as a whole gradually sinks in the public eye to a rather lower and less important status, gradually it will certainly affect the quality of entrants.

1810. I suppose so. But, of course, at the moment from the point of view of examination successes you are comparing a much wider cross-section of the public under the grant system than you used to, are you not?—Yes, unquestionably.

1811. *Sir David Hughes Parry*: Competition for entry into the medical schools is still very keen?—It is still very keen. It is less than it was a few years ago I think.

1812. *Mr. Gunlake*: Why is it possible only to judge this quality on purely subjective grounds? Surely there are statistics about the proportion passing examinations? It is not a difficult thing to study.—I think it is. In the first place I do not think that you are going to detect any big change of quality, and in the second place I think you know that some people make their own standards, do they not? If the standard of each year was one per cent. below the year before I think examiners would find themselves allowing for this and saying "this is still the thing we expect the average chap to do, he has done it, and gets through." It is difficult to compare that with, say, ten years ago.

Mr. Gunlake: It is a matter that is under continuous study in my own profession.

1813. *Chairman*: Could you make any generalisations about the comparison between here and overseas in this matter

1824. But Sir Harold says there are no figures about this yet.—*Sir Harold Boldero*: To make a comparison with that figure which has just been quoted, with which I am familiar, we have to get the same figure for ten, twenty and thirty years ago.

1825. *Mr. McIntosh*: It would be necessary to compare it with the fall off in other professions, and the sons of other professional men going into their own particular profession.—Yes.

1826. *Sir Hugh Watson*: It is fair to keep in view, is it not, that new professions are springing up every day almost, and particularly since the war.—*Dr. Platt*: I suppose so, yes.

1827. I think it is so, and probably the doctors must expect to have reasonable competition from these new professions.—Yes.

1828. *Chairman*: Even industry and commerce are much more acceptable to sons of doctors than they were, say, three generations ago.—Probably so, yes.

1829. *Sir Hugh Watson*: It is much more respectable to go into industry or commerce now than it was.—Yes. It was always respectable if you made enough money.

1830. It does not infer the same loss of social status. Could we now turn to a matter which has been very much discussed before the Commission with various people, and that is the question of merit awards. In principle I understand there is no doubt that you agree that such a thing is good?—Absolutely.

1831. The first difficulty which we encountered in considering this was the question of secrecy.—Yes.

1832. It was put to us that it appeared to be an unfortunate thing that a man might be in the position that his junior had a merit award and he would not know anything about it.—That is a good thing, is it not?

1833. That is what we thought, but that is a way we had it put to us.—That he should not know anything about it I should have thought was a good thing.

1834. It is quite clear, is it not, the public must not know?—I would really say so. I honestly would say that, yes.

1835. That is certainly your view?—Yes.

1836. *Chairman*: They must not know about individuals?—Yes.

1837. They must know a bit about the broad principle, and, in fact, if they take the trouble they know a little about it now.—They know as much as they like.

1838. But not individuals.—But I do not think they should have knowledge about individuals. I do not think this is really a new principle. I do not know what your salaries are, for example. It is not the usual thing, is it, for people to know what everybody is making.

1839. *Sir Hugh Watson*: Not in this country. *Dr. Platt*, it being agreed that the public must not know about this, would it be possible to find a way in which the holders of these awards could be known to the profession without it becoming known to the public?—I really do not think it would. At least I cannot see any way in which this could be done. I think these things have to be either really public, or else kept to a very small body of people who are very responsible people who have the doing of this kind of thing.

1840. That leads me on to the next question. We had evidence, as you know, from Lord Moran.—Yes.

1841. And we gather from Lord Moran that he thought that the method by which these awards are made was pretty generally known in the profession. Would you think that that was so in your knowledge and experience?—I think it ought to be, because I know that Lord Moran has taken the greatest of care and has gone round all centres and institutes once a year at least. He takes great trouble to explain what is going on, but only perhaps 20 per cent. or less of the consultants of the district are likely to turn up to any of those meetings; if the remainder say: "We are never told anything," I suppose Lord Moran has no way of overcoming that.

1842. If they do not turn up it would lead one to suppose they are not very much concerned about the thing?—That is right, until something spurs them on to wonder what is happening.

1843. Lord Moran makes these evangelical expeditions, and he is at pains to let it be known that he is doing this?—I think so.

1844. But, if I may say so, you did not quite answer my question. Would you of your own knowledge say that the methods by which this scheme is administered are well known to consultants?—They do not seem to be as well known as I think they should be. There seems to be quite a body of opinion which says: "We do not know what is going on."

Sir Hugh Watson: That is what I feared.

1845. *Mr. McIntosh:* Is it available in print?—*Sir Russell Brain:* I think there are different ways in which most of them can be informed. There is one way we have heard already, that all local consultants are informed of Lord Moran's visit and have the opportunity of attending his meetings. And then the various teaching hospitals and the Regional Hospital Boards are consulted, the various specialist hospitals are consulted, and the Colleges are consulted. So that there is a very large number of individuals concerned who hear about it in one way or another.

1846. *Chairman:* Would you agree, Sir Russell, with the impression that we are getting very strongly that in fact a great many of the consultants do not know, even if it is their own fault they do not know?

Sir Hugh Watson: Could I qualify the Chairman's question and say according to what I have heard a great many consultants in what you call the periphery do not know?—It may be a fair proportion do not know, but I think that they all have the opportunity of knowing.

Sir Hugh Watson: Lord Moran mentioned the case of Newcastle, and said when he went to Newcastle he drew people up from Darlington, and so on, but only a small percentage of them came . . .

Chairman: Newcastle was the place where most came. In most other places it was far fewer.

1847. *Professor Jewkes:* Could we draw a conclusion from this that the doctors do not want to know? If there are these meetings and they do not attend they do not really want to know?—*Dr. Platt:* I think that is a perfectly fair conclusion, but they might suddenly, because they think some injustice has been done, wonder why they have not been informed.

1848. We can also say that Lord Moran spent a whole day explaining to us the method by which these merit awards were granted, that his statement was taken down verbatim, will be printed, and therefore will be available to all the consultants who think they do not know and who want to know?—That is right.

1849. There cannot be any excuse in future for people saying they do not know?—I do not think there is any really valid excuse for their ignorance.

1850. *Sir Hugh Watson:* Dr. Platt, can you tell me this? Would you say that by and large, so far as you know, not only the principle but the method by which these awards are made is approved by the profession?—Yes, I would say that it is approved by at any rate those members of the profession who have seriously thought about this matter.

1851. We have not had any very clear evidence of disapproval, but there seem to be in some places some sort of mutterings about the thing.—Yes. I think there are bound to be, are there not, in any system which acknowledges that one person is rather better than another.

Sir Hugh Watson: I think that is probably fair enough.

1852. *Chairman:* Do you think, Dr. Platt, that those mutterings are fairly widespread, or not?—I really do not think they are. No, I do not think so.

1853. *Sir David Hughes Parry:* Do you think the criteria are fairly well known? I have been in some difficulty personally over that. It may be the people do not know quite for what the merit awards are given, and what sort of considerations are in the mind of the Awards Committee?—Yes.

1854. They know generally about the merit award, and they know that there is a field of consultation before they are awarded, but they do not quite know for what they are awarded?—That may well be true, because I think it would be almost impossible to define in any case a set of conditions which work towards getting a merit award, because different qualities are considered. That is one of the reasons why, of course, we think the public should not

know about it. The public may not think Dr. A is better than Dr. B, whereas it may be that Dr. A has contributed a great deal more knowledge on his subject than Dr. B.

1855. *Sir Hugh Watson*: This matter is complicated, is it not, by the influx into the major specialties?—Is it?

1856. We have had Lord Moran describe to us how he endeavoured to allocate the awards both geographically and as between specialties.—That is right.

1857. If you have got 5,000 consultants in general medicine, and only a small number in psychiatry, it becomes more difficult, does it not?—It does become more difficult.

1858. And the incidence of awards to people in general medicine or general surgery might seem much less than in the other ones?—Yes, it might seem much less, but I think the reasonable man would want to know what the statistics were before he could set out to judge it, would he not?

1859. Again these statistics are available to some of us, but I do not suppose all consultants have them.—I am sure they have not.

1860. The mutterings might be completely unfounded?—Yes, very true.

1861. *Professor Jewkes*: We find ourselves in this position, that perhaps at one and the same time people are saying "The fault of the merit awards is that we do not know who gets them because of the secrecy, but we also think the wrong people get them." Is that the argument?—Yes.

1862. They do not know them, but they think the wrong people are getting them?—I suppose there are some people who think that, but this has not come to my knowledge. I talk to a lot of men in my profession who are much younger than I am, whom I know and am quite friendly with, and I do not hear these mutterings. You get a few letters, of course, to the medical press now and then, but you cannot really think that they are representative of the whole profession.

1863. *Sir David Hughes Parry*: I wonder whether the word "merit" is the trouble? After all, this is a method of remuneration of persons on the higher level, is it not? I wonder

whether the word "merit" does not rather detract from the method of remuneration and people have rather laid too much emphasis on the word "merit"? It is really a method of remuneration, of recognition.—Yes, but it is recognition of merit or distinction, is it not? It is called a distinction award, is it not? I am not quite sure what the official form is.

1864. *Chairman*: Spens says: ". . . selecting individual specialists whose outstanding distinction merits a higher reward . . ."—I think it has to be accepted that this is not just an award for seniority. That is really the distinction that it is making, is it not?

1865. Yes.—That you do not get this automatically by living to be a certain age, or by becoming a physician to a London hospital. That was the whole idea of the Spens Committee, and I personally believe it was the right idea.

1866. *Mr. McIntosh*: On the other hand all merit awards must be awarded.—Yes, that is so.

1867. So there is not really an absolute standard.—No, it is a competitive standard.

1868. *Sir David Hughes Parry*: And the emphasis is also laid on the word "outstanding."—Does that apply to . . . ?

1869. A third . . . —All of them, does it, the word "outstanding"?

Chairman: The Spens Report I think, Dr. Platt, was quite clear on that, but you may feel that perhaps the interpretation has rightly gone a bit beyond what Spens intended.

Sir Hugh Watson: I think it is relevant to point out that the terms of reference of Lord Moran's Committee are: "To advise the Minister of Health and the Secretary of State for Scotland which specialists engaged in the National Health Service should receive awards for professional distinction . . ." That is the expression.

1870. *Chairman*: Which is in rather more general terms than the words used by Spens himself when this was produced.—Yes.

1871. And that is the operative piece at the moment anyway.—Yes.

1872. *Professor Jewkes*: Do you think there is any danger in establishing the

system in this way—it certainly would happen I think in some other professions—that doctors embark on unnecessary research and multiplication of papers that nobody reads, and so on? Is there any danger of that arising from the merit award system?—I think it happens far more in America where there is no merit award system. I mean there is a little danger of that, of course, but I do not think it is very much. An award is an encouragement for a man to try to advance his professional work, and find out something new. That is not entirely a bad thing, is it?

Professor Jewkes: I think your answer is a conclusive one, that in a country where merit awards do not exist there is much more of this.

1873. *Chairman:* We had it from Lord Moran that in some of the specialties the level of the examinations which had to be passed—the discipline was the word used—was not yet quite as severe as in some of the older branches, and not as severe as it would be in some of the newer ones, eventually.—Yes.

1874. That must mean that, at the moment, rather an extra number of these awards come to the older branches of the profession, and that rather a smaller number will go to them in future, when the other ones get it. Would you think that that is reasonable? It would seem to mean that there is a bit of good luck going to one branch of the profession now, because the others have not got the same discipline, but they will not have that extra amount later on.—I suppose you are quite correct, are you not, in actual figures. I do not know that it amounts to very much. I do not know how much that matters.

1875. It does mean that in some branches now, really a very high proportion indeed of the consultants would probably be getting a merit award some time during the course of their careers?—Does it? It depends at what age you get it.

1876. Yes.—If a consultant's professional working life is 30 years, and if everybody got it in the last 10 years everybody would have one some time during their lifetime. If everybody got it on the day they were made a consultant—everybody who was ever going to get one—only a third would ever get it. So it depends on the average age at which such an award is given.

1877. We know those figures. They will be coming out. Lord Moran also had them. But a very large proportion of some specialties are in fact getting awards.—Yes. Some specialties are doing better than others, but it may change. That is one of the points, is it not? I am not quite sure how much it will change. I think there are certain specialties which are not so exacting as others, and never will be. Whatever kind of hurdles they erect to get into them, I do not think they will ever be as exacting as some others, and a much smaller proportion of people will tend to attain some outstanding distinction in those rather narrower specialties, I would think.

1878. *Sir Hugh Watson:* But, by and large, whether there are distinction awards or not, would you expect that the majority of people would go for what are at present the major specialties?—Yes, I would. I think the majority of young men, who aspire to be consultants, are interested in Medicine.

1879. A moment ago, you mentioned a point which touches on the next question I would like to discuss with you. It has been suggested to us that these awards should be given not for individual distinction, but for responsibility. How would you view that suggestion?—I think it was just what the Spens Committee set out to avoid, was it not? How are you going to assess responsibility? It would presumably have to be by seniority in a certain hospital. Physician to a London teaching hospital might be said to be a more responsible post than physician to a smaller non-teaching hospital and that, I think, was just what the Spens Committee wanted to avoid. If a man is going to work in what we call the periphery, he should not have to go to a London teaching hospital to earn an award, or something of that kind. I think it would lead to all those things if you altered the system. I think the way they did it was a wise way, and it has proved itself to be a wise way.

1880. You have rather anticipated my next question; the two do run together very much. The other suggestion made to us was that the award should go to the post, which is very similar to what you have been talking about.—Yes. I cannot quite see, in fact, how you can fully separate the two things.

1881. *Chairman*: In fact, for a very large majority of the awards the position, probably, would not be changed. It is the extra proportion of them who might be in the periphery, for instance, who might be changed and who would lose by this?—Precisely, yes.

1882. *Professor Jewkes*: I suppose it is true that in a great number of cases distinction and responsibility go together. One would normally expect a person of distinction to be in a responsible post; if not, it would be a very odd arrangement.—Quite true, yes. To a considerable extent it works itself out precisely in this way, of course. But I think it is better that it should work itself out, and not be attached to the post.

1883. *Chairman*: And you do not know of any difficulty, for instance, in attracting an outstanding person from overseas to an important teaching post, as it is impossible to offer him in advance a merit award?—It had not occurred to me. I can see that that might be a difficulty. I know that what I would say to the man, if he was the man we wanted, would be that within a year he would have his merit award. I mean you would not be inviting a distinguished person from overseas, who was not of that calibre, would you? I think he could be fairly well told that he could expect it.

1884. That was mentioned by someone in authority as an obstacle.—Yes.

1885. May I ask one or two more questions? We have had a paper from the Medical Research Council, in which they point out that the present system is limited, so that many research people, who had made extremely eminent contributions to the science of medicine, are in fact excluded. There may be the best reasons for that, but I would like your views as to whether you think it should be extended to cover anybody just beyond the present range of those to whom it applies, and if so how?—I have been a member of the Medical Research Council, and of course I do fully appreciate this difficulty. If you make the dividing line anything other than clinical, which is the present dividing line, it does get you into tremendous difficulties. I mean you may say why should not your most eminent physiologist—a far more eminent man than most of the clinicians—get it, and then

you may say why should not the non-medical biochemists get it, and then why should not everybody get it? Finally, the only line I think you can draw is the line of clinical responsibility. I think that is what was meant originally. I think there are, perhaps, a few difficult cases where research workers have not got an honorary contract with the Health Service, and although they are, perhaps, doing work of clinical importance they do not come into the merit awards system, almost because of some administrative reason. I imagine that it is the business of the Medical Research Council to look after that kind of thing, as far as it can.

1886. They could look after that in one way or another?—I do not know that they can in all cases. I think that there are cases in which a wider interpretation of this clinical responsibility might be made.

1887. But, obviously, you would not like at the moment, without more thought, to make suggestions as to any other categories which could be brought in, without extending it in a hopelessly unmethodical way?—No.

1888. If you would care to give some thought to that . . . —I have given so much thought to it in the past, and never have been able to find the perfect solution. I think these people should be rewarded through some other means. I think that is really the answer.

1889. I think we have also had some somewhat similar suggestions made about medical superintendents or administrators. You would feel the same thing there, that the clinical line is the most practical one?—Yes.

1890. *Sir Hugh Watson*: Could we turn for a moment to considering the question that was touched on this morning of the part-timers against the whole-time consultants?—Yes.

1891. I think I am right in thinking that some of you were in on the discussions which led to the inception of the National Health Service?—Yes. I was not myself.

1892. I suppose at that time that those who were engaged in discussions with the Ministry were anxious to make sure that there would be sufficient inducement for consultants to go part-time. Would that be a reasonable assumption?

—*Sir Harold Boldero*: Having been at those discussions, I wonder if I might answer that. I do not think that that is quite the interpretation I would have put on it. I think they wished to perpetuate something. Here was a profession working outside the Health Service, altogether. To start a comprehensive Health Service one of the guiding principles at its initiation was to follow the existing pattern of medicine. There were already whole-timers—very few—but most of the hospitals, teaching ones especially, were staffed by part-time consultants.

1893. By part-time, voluntary, unpaid consultants?—Yes. It was not decided that you would want so many whole-time workers, so many half-time and so many quarter-time. That has never been present in any such discussion.

1894. It has been made clear to us, and, indeed, you make the point in your memorandum that there is very considerable tax disincentive to the whole-time consultant. Or, putting it the other way, there are various ways in which the part-time consultant can escape tax, which the whole-time consultant does not enjoy. On top of that, the whole-time consultant labours under this disadvantage about the 8 domiciliary visits. He has got to make 8 domiciliary visits, before he can get a fee for the ninth one. Then the part-time consultant who does 9 sessions gets paid for 9½. He can take his car to his office, and so on, and the whole-time consultant cannot. We understand from the evidence which was given by Sir Russell Brain, Mr. Holmes Sellors and their colleagues the other day, that, really, the principle thing about the part-time service, in the eyes of your profession, is that it retains to a certain extent an element of freedom. That is the thing on which Sir Russell and his colleagues laid stress.—*Dr. Platt*: Yes, and I would say the element of private consulting practice, which is very important. When I say "very important" I do not mean purely from the financial point of view.

1895. I know you do not, Doctor, but this matter was naturally pressed on us by the whole-time consultants, who feel that they are at a disadvantage.—Yes.

1896. The point I really wanted to put to you was this. We rather gather that there is a trend towards part-time work.

Would you feel that that trend ought not to be allowed to go too far, and that, perhaps, the time will come when some of these matters should be remedied?

—No, because I do not personally see any disadvantage in a hospital being staffed entirely by part-time people, so long as they are putting a substantial amount of their time into their hospital work. With the exception of whole-time university people, who I do not think we are considering in this—you cannot have university units unless people are working on a whole-time basis—I do not think there would be any great harm coming to the hospital service if all the whole-timers suddenly went on to maximum part-time.

1897. You would not think that was really cause for concern?—No. I would be more concerned if it was happening the other way round, quite frankly.

1898. *Professor Jewkes*: Could you enlarge on this advantage of private consulting practice? You said you attach great importance to that.—I do. I think that is a great experience for a man. I was in private consulting practice before the war. I then went into the Army, then I came back to be a whole-time professor, and the thing I miss is the consultations. But I have had this experience, so it does not matter very much. But I think that, if a man is wanting to practise medicine to the best of his ability, he likes to practise part of it, at any rate, amongst the higher paid and, on the average, more intelligent members of the public, who are more demanding of the best that he can give. I am sure it does him some good. Also, it is done under conditions where he can spend more time with each patient. We try and do our best for hospital patients, but the Health Service cannot afford that every patient can have an hour of the consultant's time, or something like that. It cannot be done. I think to practise medicine under these other circumstances is good for a man, and puts him on his mettle, if you like. I think it has value, even if it were never paid for at all.

1899. *Chairman*: But the trend is not merely from whole-time to part-time; it is from whole-time to maximum part-time.—Yes.

1900. Which does suggest that perhaps the scales are very much weighted in favour of that, partly for income tax reasons, and partly for other reasons. Would you think that that is so?—I think that is quite true. I think the income tax reasons are important ones. Do not let me give any impression that I am against the whole-timer. I think there are many men who do extraordinarily good work as whole-timers, but I do think this experience is important.

1901. *Professor Jewkes*: There may be a number of men who would probably find they could work much better as whole-time consultants. People differ in these matters.—Yes.

1902. *Chairman*: There are certain specialties where it is very much more difficult than in other specialties to get part-time work.—Yes. There are some in which you are almost bound to be whole-time, I would say.

1903. *Sir Hugh Watson*: The thing that is worrying me is this. Let us assume that the part-time consultant gets all the benefits from private practice, which you told us of—and those which you have told us he gets I am sure he does get. Apart from this question of tax is there any reason why he should continue to be treated in this selective way, as compared with his whole-time colleague? Why should he be paid 9½ sessions for doing 9? Why should he be treated differently in the way of domiciliary visits? Why should he be treated differently in the way of car expenses, and so on?—I see no reason why he should be treated differently with regard to income tax. I think the half session was, perhaps, a different matter. It was done on the assumption that if a man is engaged for so many sessions that is his actual working time; he fulfils his obligations in doing those, but in addition everybody knows that he spends extra time doing committee work, seeing emergencies and so on, so he is given a bonus for that. I think that was the idea behind it. So I think he is probably entitled to it. But with regard to income tax concessions—of course my income is Schedule E—there are very considerable disadvantages.

1904. And then there was the question of study leave, for instance.—The whole-timer is entitled to that, of course.

1905. I understand that the position is this, that the whole-time consultant is invited to go to a certain place abroad and deliver a lecture. He is treated in one way. If he wants to go to a conference abroad, and does not deliver a lecture, then he is treated in another way altogether. It has been suggested that that is unfair to him.—These things are not sharply laid down; they differ from one place to another. But the general criteria are, as you have stated, that a man has to be invited to give a paper or something, in order to have his expenses paid, whereas a part-timer can, presumably, claim some of those from his income tax.—*Sir Russell Brain*: No, not for attending conferences, but, of course, there are university posts where the incumbent's salary goes on if he goes abroad to teach elsewhere, whereas the part-timer, after he has exhausted his allowance for leave, is not paid. It is not quite all on one side.

1906. *Professor Jewkes*: Would it ever happen that a whole-time consultant might go away for, say, three months and continue to have his salary paid by the Regional Board?—*Dr. Platt*: I think so, yes.

1907. Whereas that would not occur with a part-timer?—No.

Professor Jewkes: So the advantages are not all on one side, as is sometimes suggested?

1908. *Chairman*: In general, Dr. Platt, would you feel that there was a fairly strong feeling, and a fairly widespread one, that the whole-timers come off rather less well?—Yes, that would be my impression.

1909. We are also told that very often, because they do not have as big a car as the part-timers, partly for tax reasons and other things like that, they reckon their prestige is not quite as high as some others. Would you think that that was an exaggeration, or that there was something in it?—I think there is something in it, yes, and I think that there are certain members of the public who judge people by that.

1910. The point put to us, I think, was that the part-timer could use the big car as a means of attracting suitable patients.—Yes.

1911. *Sir Hugh Watson*: I have no more questions on that subject, unless any other member of the Commission would like to ask something. On page 327 you mention the Whitley machinery, which you say has not worked well, and you rather compare it to the exercise of the Russian veto. But I am given to understand that, in fact, no fewer than 34 agreements of the Whitley Council concerning hospital medical staff have been arrived at, most of which have improved the conditions of the staff.—*Might I ask Sir Russell to answer that, because he has been on the Whitley Council for a long time, and I have only been on it since my Presidency which dates from last April.*—*Sir Russell Brain*: I am sure it is true that a number of agreements have been arrived at in Whitley, but very often after a very long and laborious discussion extending over many months. We have no record of the number which have not been agreed to, and I think everybody concerned in Whitley—and I think this is true of the Management as well as the Staff Side—feel that it is a very unsatisfactory method of trying to solve the problems we are trying to solve. The fact that it occasionally succeeds, and it is necessary to draw attention to its successes, seems to me to speak for itself without further comment.

1912. *Chairman*: Would you feel, Sir Russell, that it would be wise to try and have one method of settling really major questions affecting the whole of the profession, such as the one with which we are dealing now, and another method of a more routine nature to deal with the many questions, of which these 34 are some, that will constantly be arising in a dynamic and changing profession?—*Yes, that is our view. We think that there should be two methods but it would still, I hope, be possible to have an improved Whitley which would work better—even in dealing with small problems—than it does now.*

1913. The fact that there have been 34 negotiations completed, and a great many requests from the medical side that have not been accepted, does not necessarily mean that Whitley may, perhaps, have a more detached interest?—*It does not necessarily follow. It is possible, I think, that if Whitley were detached from the major issues it might*

be easier to solve the smaller ones, because at present they are so apt to have repercussions, one on the other.

1914. *Sir Hugh Watson*: You mentioned in the same paragraph, Sir Russell, that this involves periodic crises of an increasingly political character. But of course—and one does not complain about it—medical remuneration does amount to a vast item in the Exchequer. It is rather difficult to keep it out of the political field, in a way, is it not?—*Yes, I think that is perhaps inevitable in a National Health Service.*

1915. In the last paragraph on this page you suggest that something on the lines of the proposal of the recent Royal Commission on the Civil Service should be set up. That is the Priestley Commission, and what they suggested was a purely advisory body, was it not? I was just wondering if a purely advisory Committee would work.—*Dr. Platt*: You mean to say that after the advisory Committee had advised, it would then immediately become a political matter, and all the negotiations would have to be gone through again, here?

1916. I do not mean that, necessarily. I think the experience of all of us is that a Committee, whose functions are purely advisory, does not have the same chance of getting somewhere as one which is more of an arbiter, with a final decision.—*No, that is true.*—*Sir Russell Brain*: That, of course, raises the political problem, does it not? It is hardly likely that either party would agree to an arbiter on matters involving such very large sums. I imagine the Government would have to have the last word on that from their point of view, and the doctors and dentists from theirs.

1917. I was not necessarily suggesting an arbiter. I was wondering if you could give us any help, because Priestley was purely advisory.—*Dr. Platt*: I think that is what we had in mind, but with hopes that it would be a Committee of such importance that the Government would take its advice, at any rate unless it had very very strong reasons for not doing so, which it would have to show, of course.

1918. *Professor Jewkes*: We can take it for granted, can we, that the consultants have completely lost confidence

in the Medical Whitley Councils as they have operated since 1948?—Yes.

1919. *Sir Hugh Watson*: In your conclusion, on page 328, you quote the statement of the Earl of Home in the House of Lords that "this is the first time that the State 'has had to work out a relationship with one of the great skilled professions', and to make the relationship fruitful it will need fresh methods and a fresh attitude." Have you anything particular in mind on these matters? We know quite well that there are other elements in this question, apart from remuneration with which, primarily, this Commission is concerned. Have you any other thing in mind, that you think is relevant to this Commission?—No. I think what we fear, talking on quite general principles, is British medicine being driven down to some kind of state of uniform mediocrity and not being able to hold its place in the world with American and Scandinavian medicine, and that sort of thing. Governments must realise that, really, medicine is a very expensive business, and that it goes on developing and is likely to go on costing more and more; that nearly every hospital in the country is out of date at the present time—I think I could say every one—and that, really, an enormous amount of money needs to be put into this Health Service. I think we have at some time got to face the issue as to whether they can do this, or whether they cannot, and that merely trying to keep down expenditure at every point is, eventually, going to have a very bad effect on British medicine. Doctors' salaries, as you say, are only just one part of this; other parts are developments of hospitals, developments of new specialties, and research in teaching hospitals, which is very important. But I do not know that this is relevant to your Commission.

1920. I wondered what you had in mind exactly when you put in that sentence.—Yes.

1921. *Chairman*: This is, I think, one of the few times when this word "mediocre" has, in fact, been used in the documents which have reached us, although it has been mentioned outside from time to time. There are, I would say, two ways in which remuneration can affect this question of mediocrity.

One is if the method of adjusting remuneration from time to time is not one that gives satisfaction and confidence—that is what Sir Hugh was asking you just now—and the other is if the actual method of distribution is such as to encourage mediocrity. That, it has been said, and I think it has been said today, is really very much more dangerous under the present method of payment in the general practice branch, than in the consultancy branch. There you would feel that the system, on the whole, encourages merit, distinction and hard working ability?—You see, this has been very much whittled away, has it not, since 1948? There has been no increase in the merit awards whatever, has there?

1922. No, but the system of a merit award is a good one, even if it has been whittled away?—Yes.

1923. But in the other branch of the profession it is not good? You would agree with that?—Yes.

1924. And that is something on which we would still value any private ideas that you may have, because it is of extreme importance to everybody that nothing should be mediocre. There should be no encouragement to mediocrity, anywhere.—Yes. I quite agree with you, but I did want to point out, again, that our merit awards are getting less and less worthwhile, and that the people who are, or one assumes are, at the very top of this profession have had no increase whatever in their salary. In fact, I think some of them—if they were to step into it now—would be getting less than they would have got in 1948 for doing the same job.

1925. Naturally, we regard that as very much part of our whole terms of reference, and would do so even if it were not, but I understand from Sir Russell and from the Joint Consultants' Committee that we are likely to be receiving in due course some suggestions on the way that merit awards might, perhaps be dealt with.—*Sir Russell Brain*: Certainly.

1926. But we shall no doubt consider that independently of anything else that you may put in. We have not missed that point, I can assure you, and we would not like anybody, such as one of the Royal Colleges, to miss the other

point about general practice, which also concerns us very much.—Yes, I think that is quite right.

1927. *Sir David Hughes Parry*: The expression that has been used is professional efficiency, and any system of payment ought to be favouring that, rather than mediocrity.—Yes.

1928. *Mr. Gunlake*: I would like to ask one question arising out of page 325 of the evidence. You say:

"Before the interim award, a senior registrar on the top salary of £1,400, with a wife and two children, had a purchasing power, after taxation, of well under £500 in pre-war money, whereas on the Spens recommendations he would have had—when perhaps five or ten years younger—at least £1,100 (less about £140 in taxes)."

There seems to be a suggestion in that paragraph, which is repeated a little further on, that in considering how the status has changed as compared with pre-war the right thing to do is to look at incomes after payment of tax and surtax, and not incomes before payment of tax and surtax. Surely, you are not serious in making that suggestion, if that is your suggestion.—*Dr. Platt*: I really do not know the answer to that one. I should have thought that what attracted a man was the amount of money he had to spend on things like his rent, rates and his children's education, and I thought that taxation had a very considerable bearing on that. I know, of course, that we receive certain benefits from the taxation which we pay, but, of course, to a very considerable extent they are not benefits which the medical profession particularly makes use of. I mean there is free treatment, for instance, which the medical profession has always enjoyed.—*Sir Russell Brain*: I think I see Mr. Gunlake's point. We are all subject to taxation like the weather, but even if we left that out there would still, surely, be a substantial difference between what is left in his gross salary in terms of 1939, and what Spens recommended he should have. It happens to be worked out after deduction of taxation, but I would agree that that is not the main point.

1929. What I am really suggesting, Sir Russell, is that if all the professions, yours and mine, and, indeed, all occupa-

tions other than professions, were to maintain their pre-war position in terms of the purchasing power of money, and income after taxation, the result would be economically impossible.—Yes, but within some income scales the tax is not the very large factor, and I think the principle remains.

1930. Yes, where the tax is very low I agree that the point is of less importance, but you do actually use a similar form of words on page 325, where you are referring to incomes at appreciably higher levels.—I think this point will come out in our second memorandum, which does provide some budgets.

1931. It is, if I may say so, the only occasion on which any suggestion has been made to us that it might be correct to think in terms of net income after payment of tax and surtax, in comparing present positions with pre-war positions.—I do not think that was the intention, although it is put in that way.—*Dr. Platt*: No, I do not think we intended to make a new principle there at all. It shows our financial naiveté.

1932. *Sir Hugh Watson*: I would hesitate to cross swords with my colleague across the table, but it seems to me that what you are really doing is trying to compare two net figures.—That is what I think we are trying to do.

Sir Hugh Watson: Which, at the end of the day, comes to very much the same thing, does it not?

Mr. Gunlake: I would suggest that, if we are talking in terms of net figures, then all of us have deteriorated since before the war, and there is nothing that can be done about it.

Sir Hugh Watson: I think Sir Russell Brain would agree that we are all subject to taxation, as we are all subject to the weather.

1933. *Chairman*: I think we should also say, in regard to the consultant branch of the hospital service, that as you have already pointed out you have not hitherto had, or indeed ever asked for, what the B.M.A. would call betterment on merit awards at all. In fact, the lower salary levels of the hospital service have gone up by a bigger percentage than the higher ones. That is, of course, paralleled in all walks of life, I would say, with the exception that if

would appear that the A merit award people have not gone up at all in the last 8 years, and that is not paralleled. —A and B merit awards have gone down. The total remuneration for a man holding such an award has gone down. There is a "No detriment" clause so that no single man has actually lost by this, but his successors would.

1934. Have you any further points, Dr. Platt, which you would like to make at this stage?—I do not think so, except to say that I think we shall quite shortly be presenting you with Part 2 of our memorandum. I do not know whether it was your wish that we should give oral evidence on that as well.

1935. I would rather not decide until we have seen it, and also I do not know the extent to which you and the College would wish to see all the evidence that we have had from other bodies. It may be that some of the suggestions put forward, or proposals made, by other bodies might cause you to make extra observations, including, for instance, the observations that might be made about other methods of fixing remuneration.

It may well be that you have more to say than you had previously thought. —So we will leave it that there is a willingness on our part to give oral evidence again, of course.

1936. Thank you very much.—*Sir Russell Brain*: Is the Commission publishing evidence as it goes along, or not?

1937. The Commission is publishing the oral evidence as it goes along, but as you probably appreciate it takes some time. You have, I think, a copy of the published minutes of evidence of the meeting on the 18th December with the Joint Consultants' Committee. Of course, it must take about that time, by the time it has been checked, vetted and printed. If you would wish to have access to some of the evidence received from other people, in advance of publication, for this sort of purpose we will do our best to arrange it, most certainly.—*Dr. Platt*: We could ask for it, if we wanted it.

Chairman: If there is nothing else, that concludes the session for today. Thank you very much.

(The witnesses withdrew.)

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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

8

Eighth Day, Thursday, 6th February, 1958

WITNESSES

General Dental Practitioners Association

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Witnesses

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

EIGHTH DAY

Thursday, 6th February, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MR. A. D. BONHAM-CARTER, T.D.

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

SIR DAVID HUGHES PARRY, Q.C.

MR. I. D. MCINTOSH, M.A.

SIR HUGH WATSON, D.K.S.

MR. S. WATSON, C.B.E.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

GENERAL DENTAL PRACTITIONERS ASSOCIATION

Memorandum to the Royal Commission on Doctors' and Dentists' Remuneration

The average earnings and the hours of work report has been prepared by the Intelligence Unit of the Economist and is given as a separate section of this Memorandum. Figures and other information set out by the Economist, are based on details furnished by the General Dental Practitioners Association.

The present dissatisfaction of the Dental Profession can be classified mainly under three separate headings as follows:—

1. *Scale of Charges*

This is entirely in the hands of the Minister and from time to time new scales have been imposed without negotiations and every succeeding one has resulted in a reduction of earnings so that since 1948 the Dentists have suffered a reduction of about 33½ per cent., if not more, although the cost of overheads, technicians' charges, materials and the cost of living has gone up. Dentists have worked longer hours in an attempt to counteract these cuts and increased overheads.

When the first reduction of over 22½ per cent. was imposed the Government undertook to revise the position after the report by the Penman Committee. When that Committee reported that the 1948 scale was in accordance with the Spens principle, the Government refused to honour its pledge and proceeded to impose a further 10 per cent. cut in fees.

2. *Administration*

The administration of the dental service is in the hands of the Dental Estimates Board, a body which the Ministry says is independent. This Board causes a great deal of annoyance and grievance by apparently conceiving its duties as that of an agent for cutting down of fees and restricting the type of work to a stereotyped pattern, which

is nearly always to the detriment of the patient and discouraging better class dentistry. This spirit pervades all the various committees of the Ministerial machinery, which is shown by:—

- (a) Delaying approvals.
- (b) Offering very low fees which the Dentists resent as being extremely unjust.
- (c) One of the main complaints is that Dentists in the past have been punished in a way that a Civil Court could not possibly do, by what can be described as harassing, or even persecution.

For instance Dentists have been fined hundreds of pounds for not sending in their completed forms within 30 days of completion. There has been in these cases no allegation that anything has been claimed falsely. What harm can have been done it is difficult to understand, nevertheless heavy fines have been imposed.

To show this spirit of hostility against the Dentist a case can be quoted where the patient has refused to return to the Dentist for "easing" and the Government has taken away from the Dentist the whole of the fee. This was illustrated in the case of a patient we will call "X," whose particulars can be quoted if the Commission desires.

3. Ancillaries

Probably the biggest fear of the Profession is that insecurity is being created by the threat of dilution. In the Dentists Act of 1956, provision is made for the training of ancillaries, who will in due course be allowed to do fillings, and the extraction of milk teeth.

This provision, we think, is the thin edge of the wedge, designed in the end to force the population into Health Centres, thus doing away with the services of the Dental Profession, as at present known, to the detriment of the public.

The present position of recruitment is only satisfactory in so far that the General Dental Council and its predecessor the Dental Board have issued propaganda which gives a very rosy picture of a dental career. This Association considers this propaganda very misleading and false.

The McNair report admits that Dentists are not recommending their sons and daughters to enter the profession.

The profession has been the subject of some false propaganda on the part of the Ministry and we are strongly of the opinion that the Government regards the Dental Service as a vote catching machine, rather than a Dental Service to the population.

We consider the shortage of Dentists would be solved by extending present facilities in the teaching Hospitals and creating new Centres of teaching rather than by way of ancillaries.

Recommendations

1. We consider that experience should have some reward to compensate for the loss of speed, and would suggest that every five years the practitioners should be graded in such a way that the youngest should get a basic pay per item, but extra should be added to this if the work has been done by a man of greater experience and this extra should be increased with the number of years of service.

2. It would seem desirable in the opinion of the General Dental Practitioners Association, first to eliminate the power of the Minister to constantly reduce the scale of charges on a unilateral basis and make the Ministry capable of being sued in a Civil Court for breach of contract, and making the fines the Ministry imposes, through the Executive Councils, able to be revised in Civil Courts in the ordinary way of a civil action.

We would, therefore, summarise the position as follows:—

A special Act should be passed taking away the right of the Minister to change the scale of fees and conditions of Service unilaterally and to acknowledge that the Profession entered the National Health Service on the understanding that the Spens report was the basis of the contract, and we ask the Commission to declare that this is a desirable fact, and the Ministry should base future remuneration on that assumption.

3. We consider both the Minister and the Dental Estimates Board should be subject to action in the Civil Courts. So called "appeals" to the Ministry are in all cases undemocratic because the Ministry is both judge and jury in its own cause.

4. In cases of dispute over conditions of service, this Association considers that the Profession should have the right to appeal to independent arbitration.

5. We would urge that the part of the Dental Act allowing dilution be repealed forthwith.

We would like the Commission to recognise the plain truth that the dental studies last at least five years, and cost not less than £2,500 and that much again is required to purchase a practice or equip one (and in addition the dentist has to provide premises, the costs of which are very high, especially in some areas). He also has to work for about six months with very little income, so must have enough capital to carry him through this period. Also that dentistry is not only a learned profession requiring long years of training and experience, but it is in point of fact a very arduous occupation, in artificial light, in positions of discomfort to the body and that with overwork and worry the Dentist is liable to suffer in health.

All this must be taken into consideration when comparing the earnings of the Dentists with those of other professions, training time for which is often not so long nor the capital expenditure so heavy.

6. As the Commission will no doubt acknowledge the recommendations of the Spens Committee as the basis for calculating remuneration, we consider that the Minister has created great hardship in the Dental Profession by withholding monies which were rightfully due, and we suggest that the Commission recommends the return of that money retrospectively.

THE REMUNERATION OF GENERAL DENTAL PRACTITIONERS

JULY, 1957

THE ECONOMIST INTELLIGENCE UNIT LIMITED,

22, RYDER STREET, LONDON, S.W.1

The Remuneration of General Dental Practitioners

The main purpose of this report is to analyse the returns to a questionnaire on dentists' earnings, which was sent out by the General Dental Practitioners Association. The questionnaire was devised by the Association, in conjunction with The Economist Intelligence Unit Limited, and was chiefly designed to show net incomes in 1953, 1954, 1955 and 1956, in order that a comparison could be made with the recommendations of the Spens Report on the Remuneration of General Dental Practitioners.

The response to the questionnaire was sufficient to give a general picture of dentists' remuneration in each of the above years. In the case of the hours worked, however, the very wide variation in the figures given must in part be due to a confusion as to whether the chairside or total hours worked were required, and this made it very difficult to draw any conclusions from these figures.

In addition to the analysis of the returns, a brief note has been added on the value of the goodwill of a dental practice. To do this, the advice of two major dental agencies which sell dental practices was obtained, and the information they were able to give, which was largely the same in both cases, has been summarised in an appendix to the report.

Dentists' Remuneration

For the purpose of this survey, it was necessary to find out the net incomes of dentists in the General Dental Practitioners Association, in each of the years, 1953, 1954, 1955 and 1956. The method used to obtain these figures was to ask for the gross incomes from dental practices in each of these years, plus a detailed account of the expenses which were allowable for income tax purposes by the Inland Revenue. To all intents and purposes, the net incomes derived from these figures apply entirely to work done under the National Health Service. Private work was not undertaken by the majority of the dentists concerned, and where it was done it rarely amounted to more than 2-3 per cent. of the total time spent in practice during the year.

A summary of the results, showing the net income distribution by age groups for the years 1953-55 is given in Table 1 below:—

TABLE 1
NET INCOMES
Percentage Distribution by Age Groups in 1953-55
Age Groups

Income £ p.a.	-30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Under 500 ...	20.0	9.1	—	6.0	31.8	—	7.5	32.4	54.5
500-999 ...	6.7	9.1	13.8	8.0	9.1	6.5	28.4	35.2	15.2
1,000-1,499 ...	26.7	13.6	37.9	16.0	31.8	29.0	24.5	21.6	15.2
1,500-1,999 ...	20.0	36.4	13.8	24.0	22.7	29.0	17.0	2.7	6.1
2,000-2,499 ...	—	22.7	20.7	10.0	4.6	22.6	11.3	2.7	4.5
2,500-2,999 ...	—	9.1	10.3	8.0	—	9.7	7.5	5.4	—
3,000 plus ...	26.6	—	3.5	28.0	—	3.2	3.8	—	4.5
TOTAL ...	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

If attention is concentrated on the age groups from 35 to 54 inclusive—in which the majority of established full-time dentists are to be found—the position in the years 1953-55 was as follows:

16.7 per cent. had net incomes below £1,000 a year

43.2 per cent. had net incomes below £1,500 a year

65.9 per cent. had net incomes below £2,000 a year

and 80.3 per cent. had net incomes below £2,500 a year

It can be seen that there is a very wide range of incomes in the dentist's profession, and it is difficult to talk in terms of an average income. It is interesting to note, however, that the variations are chiefly due to differences in gross income. For, in the majority of practices, there is a considerable degree of similarity between hours worked and total expenses, yet the total turnover often varies very widely. It was pointed out by the Spens Committee that "Any system of remuneration based on the number of dental operations performed puts a premium on the speed of working," and that this could prove detrimental to good workmanship. The Committee considered that adequate remuneration, especially for outstanding work, plus the traditional high standards within the profession, would obviate any such risk, but this view does perhaps need reconsidering when a sense of grievance over inadequate remuneration is known to exist.

A picture of the changes that have taken place in salaries during the last four years is given in Table 2, which shows the average salary for each age-group, and the average for the dentists as a whole, in each year from 1953 to 1956.

TABLE 2
AVERAGE NET INCOMES BY AGE GROUPS

Age Group	1953*		1954*		1955*		1956*	
	% of Av. Net		% of Av. Net		% of Av. Net		% of Av. Net	
	Total Income		Total Income		Total Income		Total Income	
	(£)		(£)		(£)		(£)	
Under 30	2.1	2,155	2.8	1,996	6.3	2,077	8.1	2,827
30-34	7.1	1,514	7.3	1,789	6.3	1,869	6.8	1,606
35-39	8.2	1,433	9.2	1,609	9.9	1,990	6.8	2,176
40-44	15.3	2,360	14.7	2,517	15.3	2,660	13.5	2,637
45-49	6.1	996	4.6	1,249	5.4	1,469	5.4	1,724
50-54	10.2	1,574	11.0	1,618	9.0	1,970	6.8	1,708
55-59	16.3	1,321	16.5	1,421	15.4	1,766	13.5	1,790
60-64	8.2	1,075	10.1	1,005	8.1	1,302	9.4	1,166
65 plus	20.4	830	18.3	848	18.0	1,010	21.6	893
Others†	6.1	1,690	5.5	1,708	6.3	1,758	8.1	1,837
TOTAL	100.0	1,429	100.0	1,525	100.0	1,777	100.0	1,774

* Calendar years or financial years falling mainly within the calendar year.

† Ages not specified.

It can be seen from this table that the general trend in incomes has been upwards, although there was a downturn in the average income in 1956. As far as it was possible to tell, there has also been a slight tendency to work longer hours, but as in the majority of cases it is not certain whether chairside or total hours worked are given, this must be a somewhat tentative conclusion. In terms of fixed 1953 prices, the changes in total average income have been from £1,429 a year in 1953 to £1,484 in 1954, £1,648 in 1955 and £1,542 in 1956; so that there was also a decline in real income during the past year.

[It should be borne in mind that the number of returns for 1956 was considerably less than in the previous year, amounting only to some 60 per cent. of the earlier totals, and that this may be falsifying the picture to a certain extent.]

More interesting, however, is the relation of present day salaries to the pre-war position. This enables a comparison to be made with the recommendations of the Spens Committee. The figures in Table 2 have, therefore, been deflated by the rise in the cost-of-living since 1938, and the results are shown in Table 3 below.

TABLE 3
AVERAGE NET INCOMES BY AGE GROUPS AT 1938 PRICES

Age Group	1953*		1954*		1955*		1956*	
	% of Av. Net		% of Av. Net		% of Av. Net		% of Av. Net	
	Total Income		Total Income		Total Income		Total Income	
	(£)		(£)		(£)		(£)	
Under 30	2.1	826	2.8	759	6.3	753	8.1	975
30-34	7.1	591	7.3	680	6.3	677	6.8	554
35-39	8.2	560	9.2	612	9.9	721	6.8	750
40-44	15.3	922	14.7	957	15.3	964	13.5	909
45-49	6.1	389	4.6	475	5.4	532	5.4	594
50-54	10.2	615	11.0	615	9.0	714	6.8	589
55-59	16.3	516	16.5	540	15.4	640	13.5	617
60-64	8.2	420	10.1	382	8.1	472	9.4	402
65 plus	20.4	324	18.3	322	18.0	366	21.6	308
Others†	6.1	660	5.5	650	6.3	637	8.1	634
TOTAL	100.0	558	100.0	580	100.0	644	100.0	601

* Calendar years or financial years falling mainly within the calendar year.

† Ages not specified.

The Spens Committee's recommendations on the general level of salaries in a public dental service were as follows:—

"If there were sufficient dental practitioners in relation to the demand for their services to secure a spread of incomes comparable to that in 1938, arrangements should be made to ensure that between 35 and 54 years of age 75 per cent. of those practitioners should receive net annual incomes of over £850, 50 per cent. of them should receive incomes of over £1,100 and 25 per cent. incomes of over £1,400 . . . These recommendations are expressed in terms of the 1939 value of money" (Para. 32).

The Committee went on to recommend that until there were sufficient dentists to achieve this 1938 spread of incomes, that it should be possible for a single-handed practitioner working efficiently for 1,500 hours a year at the chairside to earn a net income of £1,600 in terms of 1939 prices.

It can be easily seen from Table 3, that the present situation in no way corresponds to these recommendations. In only one age group, 40-44, does the annual average salary exceed the £850 a year mark, and then only by a small margin, whilst in all the other ranges, with one exception, the salaries fall considerably below this level. Also in no case where the hours worked were stated, were they as low as 33 hours a week for full-time dentists—the average was about 40-44 hours a week—yet the Spens Committee declared, "We are satisfied by a large volume of evidence that only exceptional practitioners will be able to work for any prolonged period without loss of efficiency or indeed without damage to health for substantially more than 33 chairside hours a week." The position at the present time is, therefore, that the majority of dentists are working longer hours than was envisaged for something between a third and a half less remuneration, in real terms, than it was recommended that they should receive. As for the recommendation that it should be possible to earn £1,600 a year in terms of 1939 prices, without working more than 33 chairside hours a week, this appears to be a virtual impossibility in terms of the current remuneration. [Owing to the distortions caused by the outbreak of war in 1939 it has not been possible to express current incomes in terms of 1939 prices, but the difference caused by using 1938 prices is insufficient to affect the general argument given above.]

It follows from this survey that the dentists in the General Dental Practitioners Association are considerably worse off under the National Health Service than they were led to believe they would be by the Report of the Spens Committee. This applies not only to their total remuneration but also to the hours they are required to work in order to earn their current lower incomes. The recommendations of the Spens Committee, when turned into current prices, mean that some 75 per cent. of practitioners should receive more than £2,400 a year in present day prices, and 50 per cent. should receive more than £3,000 a year, if the supply position is comparable with that of 1938. Although it would appear that the Committee was, perhaps, unduly generous in its recommendations, largely because it did not stop to consider what the sums involved would total in terms of present-day prices, a substantial increase in dentists' salaries seems both just, and necessary if the Service is to continue to work satisfactorily. This is especially so when the method of payment puts a premium on speedy rather than conscientious work, even in a profession with such traditionally high standards as the Dental.

APPENDIX 1

Methods of Compilation

1. Throughout the report, all the income figures refer to net incomes before tax. These were calculated by deducting all the business expenses allowable by the Inland Revenue for income tax purposes from the gross incomes or turnover of the practices. In cases of partnership, unless there was any information to the contrary, the net incomes so derived were then considered to be divided equally between the partners.

2. Completed questionnaires were sent in by some 12 per cent. of the total membership of the General Dental Practitioners Association. Owing to the difficulty of obtaining audited figures for the most recent year, however, only about half of these returns were completed for 1956.

3. The majority of the replies in the under 30 age-group came from Assistants. These received a fixed salary plus, in some instances, a bonus calculated on the turnover of the practice. It is interesting to note, therefore, that they formed the second highest paid age-group in the entire profession.

4. The largest number of returns for any one age-group came from those over 65 years of age. As many of the dentists in this group were earning very low, and in some cases, minus net incomes, their inclusion has tended to reduce the average net income for dentists as a whole. In order not to include those who only worked part-time, all the dentists over 65 who worked less than 15 hours a week were excluded from the calculations in Table 2 and 3.

5. The measure used to deflate the present day salaries was a middle class cost-of-living index compiled by the Economist, relating to the salary range £500-700 a year in 1938. The figure at the end of each calendar year was taken as representing the average for the year as a whole, as the majority of the financial years tended to fall mid-way between the calendar years. The actual indices used are shown in the table below, and for comparison purposes, a general retail price index, compiled by the London and Cambridge Economic Service, is also given.

Cost of Living Indices
(1938=100)

	<i>Middle Class</i> £500-700 p.a.	<i>Retail Prices</i>
End 1952	248	221*
End 1953	256	228*
End 1954	263	232*
End 1955	276	242*
End 1956	290	260†

* Yearly averages.

† January, 1957.

APPENDIX 2

A Note on Goodwill

Many dentists who were in practice prior to the introduction of the National Health Service, and who paid certain sums of money in respect of goodwill when they purchased their practice, feel that they have almost completely lost this money because of the ease with which a practitioner now can start and build a practice merely by opening a surgery and putting up a nameplate.

This viewpoint is borne out to a considerable extent by the experience of the major agencies which deal in dental practices, although they pointed out it was unwise to generalise too much on this topic. They stated, however, that in the immediate pre-war period a fair estimate of the goodwill of a practice could be obtained by taking the yearly average turnover in the previous three years to the sale. At the present time, if the same measure was used, the amount of goodwill was considered to be approximately 25-30 per cent. of the three-years' average annual turnover by one agency, and by another it was considered to range from between 20 and 50 per cent. of this average.

It can be seen from the above that the goodwill of a dental practice has been reduced by one-half to three-quarters of its pre-war value. In fact the portion of goodwill that remains is now almost entirely due to the site value of the property—whether it is in pleasant surroundings in a well appointed district, etc.—and only in a very little degree does it represent the rewards of good service over the years. To this extent, therefore, it can be said that those dentists who purchased practices prior to 1948, and in the pre-war period especially, have to a large extent lost a sum of money which would otherwise have been recoverable at the end of their career, and to this extent that they have been made worse off by the introduction of the National Health Service.

Examination of Witnesses

DR. K. MALIK

MR. F. BARLOW

MR. R. C. BRENNAN

MR. D. DAKER

MRS. J. D. THORBURN

MR. B. DEAKIN }

MR. I. HARDER } *Economist Intelligence Unit*

on behalf of the General Dental Practitioners Association
called and examined

1938. *Chairman*: Dr. Malik, you are acting as the spokesman primarily for the General Dental Practitioners Association?—*Dr. Malik*: Yes, Sir. I have also brought members of our Head Council and representatives of the Economist Intelligence Unit here to assist me in interpreting the figures which we have offered to you.

1939. Now I would like you please to understand that we shall be wanting to test those points that we want to deal with in your memorandum quite thoroughly, because if we do not there is no one else to do so; and I want you to understand that if we question you it does not imply either disbelief or hostility towards the submissions that you have made. Equally, please also understand that our failure to pursue a point that you have made does not necessarily imply either acceptance of it or that we regard it as irrelevant. On the other hand there are some things in your memorandum that are most certainly outside our terms of reference, and while we may touch upon them it does not necessarily indicate that we shall touch on them in the report we shall eventually make on the question of dentists and their earnings. Any member of the Commission will have a chance to ask questions of you, but for convenience we have given the task of sifting the many written submissions that we have received from many bodies on the subject both of doctors and of dentists to two sub-committees. In this particular case Sir Hugh Watson has been the chairman of the sub-committee. He will, in general, be taking the lead in asking you questions on the points of interest to us.

First of all, however, Dr. Malik, would you mind telling us something about the Association—what it is, what are the qualifications for membership, and whether the membership is well spread and covers a small or a large propor-

tion of the dental practitioners, and so forth?—The qualification for membership is the name on the Dentists' Register. Our membership is a fairly good sample of the profession, consisting of those with double qualifications, the ordinary L.D.S. and the 1921 Act men. We have a goodly proportion of all the classes.

1940. How many members?—We have 1,100 members on our books.

1941. And how many are there on the Dentists Register who would be eligible?—In the Service there are just under 10,000, but on the Register itself there are near enough 16,000 this year.

1942. So that you have about 1,100 members out of a possible 16,000?—Yes, Sir.

1943. Is your membership spread throughout Great Britain—Scotland, as well as England and Wales?—Yes.

1944. And is it fairly evenly spread?—I could not be dogmatic about that, but apart from rather thick patches in areas such as Manchester and London, we have a fair sample from the whole of the United Kingdom and Ireland.

1945. Now the British Dental Association is the main body representative of dentists as a whole in this country. That is so, is it not?—Yes, Sir. I should say that is over the last few years. We were all members of the B.D.A., and we sank our individual organisations in that Association. At one time there were three organisations representing the dental profession; the Incorporated Dental Society, the Public Dental Service Association and, of course, the British Dental Association, who had about 5,000 members. Then we amalgamated, thinking we were increasing our power of resistance to any force against us. The membership of the B.D.A. increased to

12,000.) Everybody who was conscious of the need for an organisation did belong to the B.D.A.

1946. We shall, of course, take the B.D.A. evidence at length with that Association, but I really want to know what your relationships are with them, and to what extent you have either special interests or special points of view.

—Our special grievance—perhaps I should say our reason for breaking away from B.D.A. was that we found we could not affect the policy of the B.D.A. in providing us with a defensive mechanism, such as the B.M.A. built up in the early days of the National Health Service. For instance, they created the Medical Guild to protect the doctors, but the B.D.A. leaders, we thought, were more or less neglecting their duty in defending us. Year after year we suffered cuts in fees, and the conditions were getting worse. There were delays and what I have sometimes described from the platform as persecution. It is not an exaggeration when you are subjected to it from day to day; and with the perpetual questioning and delays and cuts which were imposed on us, we broke away with a view to trying to create a fighting machine to stop all this.

1947. Have you any relationship with the B.D.A. at all now?—Not very amicable, Sir. We offered to co-operate with them in fighting, but I am afraid that in our opinion the B.D.A. are in the pocket of the Government.

1948. I hope you will not start making speeches or allegations against other people.—I am sorry, Sir, that is an opinion of ours.

1949. But you now have no particular relationship with the B.D.A.?—I do not know what you mean by that—but we do hope, by our activities from the outside, to goad the B.D.A. into becoming a fighting machine, because they are a bigger organisation and they could be more effective than they are.—*Mr. Barlow*: May I say something? Actually, there are members of this Council here who are also members of the B.D.A., and a lot of us belong to both Associations; so there is quite a connection, you see, with the B.D.A. A lot of us have joined this Association in the hope that there would be more resistance here—but we belong to both.

—*Mr. Brennan*: Mr. Chairman, may I make just one observation? The point arose about membership and the total number of men on the Register and the total number of members of this Association, the General Dental Practitioners Association. Now the general practitioner is the man who engages in a State practice. Consequently our point has been largely over fees and conditions of service. That is a thing which would not interest a very large proportion of the members who are on the Register generally. They may be in hospital work or they may be men in private practice. Many of them are men who have no relations whatever with State practice.

1950. If I take your point, Mr. Brennan, you say that your membership of 1,100 is a certain proportion of the dental practitioners as a whole. Can you tell me how much?—Yes, there are nearly 10,000 men on the Executive Council lists—that is the men who engage in State practice.

1951.—So you say you are 1,100 out of 10,000?—Exactly: not strictly and rationally 1,100 out of 16,000.

1952. *Sir David Hughes Parry*: Have you any members who are outside England and Wales and Scotland?—*Dr. Malik*: There are a few in Northern Ireland.

1953. *Chairman*: And the objects of the Association in principle then, Dr. Malik, are to fight for improved terms for the dentists—is that right?—Yes, Sir.

1954. They do not go beyond that—that is the primary object of this particular Association?—Yes, Sir.—*Mr. Barlow*: If it would help you, I have a list of members of this Association, which shows in which areas and counties they are in practice. It might be helpful to you.—*Chairman*: Thank you. We do not want to go into any greater detail, but if you would like to leave it with the Secretary later, that might be of use. Now you have submitted to us a memorandum, and we will talk about that in a few minutes. But you included with it a questionnaire that you have compiled about dentists' earnings, made for you by the Economist Intelligence Unit. We would like to ask you a few questions about that.

1955. *Sir Hugh Watson*: You have told us that your Association exists

largely to protect dentists, and I gather from what you are saying that one of the things against which protection is needed is declining remuneration?—*Dr. Malik*: And the introduction of dilution. In my opinion—and I am a member both of the General Council and of the Experimental Committee—I think that within a reasonably short time, say 10 to 15 years, the practice of dentistry as we know it today will be abolished; the health centres will take over and the semi-trained people will do the bulk of the work; and the dentist will be found redundant.

1956. We will come on to that in a moment. What I wanted to ask you just now was this—do all these matters, does your Association have any negotiations with the Ministry of Health?—I think that the Ministry will take great care not to recognise us officially because that would go against their friends, the B.D.A.

1957. *Chairman*: Are you suggesting that the B.D.A. should not be the recognised body for the dental profession?—I suggest, Sir, that we have every right to be recognised too. I think that the Government prefers to deal with "Yes men", and we have proved in the election to the General Dental Council that we have a very, very substantial representation—more than 20 per cent. representation—of the electors. For instance, I topped the poll when there was no election for the General Dental Council; on the policy of this Association I obtained the largest number of votes. Then our candidate, last June when there was a bye-election, obtained 37 per cent. of the votes of the electors, in spite of the open challenge by the B.D.A., who supported only one candidate. So I think there is a very strong case for the Government to call us into these bodies and ask our opinions, but we have applied and found them deaf and dumb and blind.

1958. Well, that is a pretty sweeping statement. But you say you are yourself a member of the General Dental Council?—Yes, Sir.

1959. And therefore you can make your own particular views known to your colleagues on the Council?—I hope so, Sir. I was called a gadfly because I do not keep my mouth shut.

1960. Now, we will turn to this questionnaire of earnings. Could you tell us to how many dentists were these questionnaires sent out?—The whole of the Register—approximately 15,000—except those who were abroad.

1961. And how many replied?—*Mr. Harder*: There were 130 replies.

1962. 130. That is under 1 per cent. of those to whom the questionnaire was sent, is it not?—*Dr. Malik*: Those who took any notice of that request would be our members.

1963. *Sir Hugh Watson*: How do you know that?—Because I think we had a record of the names. All the questionnaires had their names on.

1964. I think we are entitled to press you a little about this. You say you think you had a record of their names. I think the Commission would like you to say whether you know definitely.—We did have a record of the names. I believe that each form had a signature with the name.—*Mr. Deakin*: Yes.—*Dr. Malik*: We sent out the questionnaire, and there was a space for the name on it.

1965. And you are in a position to assure the Commission that you know from whom the replies came?—Of the 130 replies, at least 120 are our own members. I can assure the Commission of that, yes.

1966. *Chairman*: Mr. Deakin, you are from the Unit?—*Mr. Deakin*: That is right, Sir.

1967. Have you had any experience of this sort of enquiry before?—Yes.

1968. Would you consider that that was a high rate of return?—It is a high rate, considered in relation to the number of members of the Association—12 per cent. of the Association's members is a reasonably high return.

1969. Would you consider that to be a rate from which some deductions could be drawn?—I think so, considered in relation to the General Dental Practitioners Association.

1970. *Mr. Gunlake*: And was the object of this exercise to study the incomes of the members of the Association or the incomes of dentists?—The members of the Association only.

1971. It was purely limited to that objective?—*Dr. Malik*: Well, we wanted to know the average remuneration of the panel practitioner, that is the

practitioner in the National Health Service.

1972. *Chairman*: Whether he was a member of the Association or not?—That was our object, Sir; but we found that only members of the Association took any notice of our request.

1973. And have you any particular reason to think that the members of your Association are a cross-section of the whole of the profession, or otherwise, I do not know.—Very good reason.

1974. You think they are representative?—Yes, I think so.

1975. You have a reason for thinking that?—Yes.

1976. Could you tell us what makes you think that?—Because, as I said at the beginning, we have quite a number of people who are doubly qualified; the bulk of our members are the ordinary L.D.S. men, and we have a goodly proportion of the 1921 Act men. They are spread comparatively evenly, with the exception perhaps of the areas of Manchester and London, where they are slightly more represented, but membership over the country as a whole is fairly evenly spread. As my colleague, Mr. Barlow, pointed out, from the list you may have a good idea of that spread, Sir.

1977. And have you any reason to think that the 10 per cent. or 12 per cent. of your members who replied are a fair cross-section of your total membership?—I would rather leave that to the experts on figures, but I would say so myself, yes, Sir.

1978. *Mr. Gunlake*: It is a fact, is it not, that the replies represented something like 1 per cent. of the number of dentists, but that the response from your own members was something like 12 per cent.? And if I understood you correctly, the purpose was to study the incomes of those dentists in general practice in the Health Service. It would seem that the response rate was something between 1 per cent. and 12 per cent. You are making a study here, and you comment in your document, on the way in which these incomes vary, both as regards age and as regards amount. You have a dispersion of ages from under 30 to over 65 and a dispersion of incomes from under £500 to over £3,000. Are you seriously saying that a response rate of even as much as 12 per

cent. is statistically adequate to give you a fair picture, with that kind of dispersion?—Oh yes, Sir, I would most definitely; because you are undoubtedly aware of the Spens Report, and in this Spens Report the entire replies were under 100, if I remember the figure rightly. The Government Actuary said that that was a jolly good proportion of the whole profession.

1979. Could you tell us where that figure is to be found?—I have the Spens Report here.

1980. *Chairman*: Which table are you taking?—In the preliminary remarks of the Spens Report, which was reprinted in 1955—it is marked Cmd. 7402—in the preliminary remarks it does occur, and I have seen it many, many times.

1981. I wish you could just point it out. I am not doubting it is there. There is some mention made in paragraph 9—this is what it says in paragraph 9—that as the number of replies had been less than had been hoped, some doubt existed as to the degree of reliance that could be placed on these tables. Is that the one?—That is right.

1982. I do not see yet this figure of 100 replies.—It is paragraph 9 you are reading, Sir?

1983. That was the one.—“The number of replies having been less than had been hoped, some doubt existed as to the degree of reliance which could be placed upon the picture presented by these tables. We were, however, advised by the Government Actuary that the replies could be accepted as reflecting, in a broad way, the general financial position of the profession.”

1984. You say that the total number of replies was 100?—Yes, I believe that somewhere or other the numbers were mentioned. They were extremely small.

1985. You said they were about 100, and I was just trying to find out where you got that from?—I have it in my head.

1986. *Mr. Watson*: I thought it would be in the report rather than in your head, Dr. Malik.—I could find it if you give me time. Perhaps we could promise to send it to you later on?

1987. If you are making the statement that there were only 100 replies in regard to the Spens Report, it would be

useful to have it substantiated.—It was very, very small, Sir; it is in my memory, and I have seen it somewhere. It was certainly not very much more than 100 and very, very far short of 200.

1988. Well, I would like you to try and establish that, if you can do so.—Yes. Would you like us to send you that?—*Chairman*: I would like you to tell us where that information comes from, because I cannot see it here.

1989. *Mr. Gunlake*: In any case, that relates to a judgment that was forthcoming in respect of the Spens Report. I would still like to know whether your statistical advisers sitting beside you, in regard to this investigation, are completely satisfied, as I have said, that with this dispersion as to age and income, to attempt a study with a 1 per cent. response rate is statistically satisfactory?—*Mr. Deakin*: I would say that the response rate we have taken here—and which may be seen in our notes—is approximately 12 per cent. of the members of the Association. That is quite a good sample.

1990. You think so?—Yes.

1991. *Chairman*: Mr. Deakin, you divided your Table I into 63 separate things—nine age groups and seven salary groups. You had 130 replies, so that is an average of two replies in each section?—*Mr. Harder*: It is spread over three years, so with a total of 130 replies altogether if they are broken down between three years, it would be 108 for each year—I do not think they were broken exactly in that order.

1992. Which means that there are less than two people for each year in each classification?—Well, Sir, you will see that certain classifications are left out altogether. There may indeed have been one or other classifications in which the figure was as low as two. I think in fact the lowest figure for which a percentage has been taken was three, but I can check that from my working papers.

1993. Which means one per year?—Yes, Sir; that would be the lowest figure.

Chairman: Mr. Gunlake?—*Mr. Gunlake*: I do not think I wish to pursue this question any further, thank you.

1994. *Chairman*: Mr. Daker, you would like to say something?—*Mr.*

Daker: May I compare the figures given in this table with those of the British Dental Association memorandum, on page 43, and state that they are very similar. I would also draw attention to the fact that these latter figures were taken from the Inland Revenue people. These figures give a much broader prospect—probably in the region of 500 general practitioners. That is page 43 of the British Dental Association's memorandum.

1995. In fact, Dr. Malik, the Table I in your memorandum suggests that 26 per cent. of dentists under 30 earned over £3,000 a year?—*Dr. Malik*: I leave that to the experts.

1996. Well, that is the figure—26.6 per cent. That is right, Mr. Deakin, is it not?—*Mr. Deakin*: That is how it comes out.—*Mr. Harder*: That is exactly what they said they earned: 26.6 per cent. stated that their net incomes were above £3,000.

1997. Are you suggesting that this is typical of the dental profession, Dr. Malik—that this is representative of the general practitioners' earnings? In other words, are you suggesting that 26.6 per cent. of dental practitioners under 30 earn over £3,000?—Generally speaking, the younger people earn considerably more than the others, that is true.

1998. Under 30?—The younger you are, the faster you work; and they have introduced pieceworkers. We have no effective trade union to put a limit to the earnings of active members. The trade unions actually limit the maximum earnings of their members, but a young man who finds himself able to earn, he works faster and is able to knock up this figure; that is true.

Chairman: And then, between 30 and 40, he falls off and does not earn nearly so much, and then over 40 he earns it all again. That is what you are saying here.

1999. *Mr. Bonham-Carter*: Dr. Malik, what is the average age—or can you give me a rough idea of the earliest age—at which a man can start practising on the completion of his training?—Normally, I should imagine it would be 22 or 23 when you qualified. Supposing you left school at 16 years of age and you start your professional studies, which take 4½ or 5 years, and if you fail once or twice . . .

2000. Then there is your national service to come in, at the moment?—Normally you can say that after qualification you might be asked to go into the Forces, yes; but that is comparatively recent, is it not?—*Mr. Daker*: It would be more likely to be 24 or 25.

2001. So what you are saying is—let us assume national service training at the moment—that you do get a high proportion of men starting to practise at 24 or 25?—Yes.

2002. *Sir Hugh Watson*: Which is it? *Dr. Malik* says 22 or 23 and *Mr. Daker* says it is later.—*Dr. Malik*: Many of them go on into private practice.

2003. *Mr. McIntosh*: You said they leave school at 16. Do most of the entrants to the dental schools leave at 16?—If you pass your G.E.C., yes.

2004. Would that be the majority of dentists?—No.—*Mr. Daker*: It would be about 174.

2005. *Chairman*: Well, I think we can leave the statistical part of your memorandum now. But we feel rather doubtful about the substance of the sample and of the response, *Dr. Malik*—that 1 per cent. of replies from dentists as a whole or 12 per cent. from your own membership would barely seem to be enough to rely on for a complete picture.—*Dr. Malik*: Well, Sir, in fairness to us, if the Government accepted the figure which was received in connection with the Spens investigation, I feel quite sure, compared with that, we had a very good response.

2006. *Sir Hugh Watson*: Perhaps you would agree with me that the Spens Report is now past history and that probably a better result would be obtained from the questionnaire sent out by this Commission?—Well, I hope so, Sir. But in my capacity as a general medical practitioner, the questionnaire sent by the Commission was just impossible to answer and I had to file it. I have been reminded that I should complete it, but I just find it impossible to answer.

2007. The Commission will be disappointed about that. They took the best possible advice on the subject and it seemed to them to be a reasonably simple questionnaire.—I did not find it so.

2008. *Chairman*: *Dr. Malik*, did you say there "doctor" or "dentist"?—

I said "doctor". I happen to be the only man in England who practises both. I have a very small medical practice, and I was sent a questionnaire—by chance, I suppose—I received the questionnaire on the medical side. I did attempt to answer it but I could not. I found it impossible to understand.

2009. That is very surprising, because a very large number of the doctors who received it have already answered it—a very large proportion.—I am very glad, Sir.

2010. The dentists' one has only just begun to go out, and probably none of you gentlemen will have yet received it.—I have not received that one.

2011. *Sir Hugh Watson*: *Dr. Malik*, you know the terms of remit of this Commission?—Yes, Sir. But I am sorry we conceive our duty as one of an opportunity to put things which are not strictly in your remit, because we hope that there are other ears and eyes scanning this, and that it might present a fuller picture than the limited remit of this Commission.

2012. Of course, I am not objecting to that. I am merely asking you if you are familiar with the terms of our remit.—Yes.

2013. And you know that our business is to look into the remuneration of doctors and dentists within the National Health Service and into the remuneration of doctors and dentists outside the National Health Service and to compare the incomes of other professional people, and then to make recommendations as to what, in our opinion, ought to be the proper level of remuneration?—Yes.

2014. Now that being so, would you agree that past history, while relevant, is not a deciding factor in this matter? I do not propose to go through the history of the various steps that have taken place, but are you aware that, following on the investigation which took place in 1952 and 1953, the profession entered into an agreement with the Ministry?—Yes, Sir. I would say that the profession did not but that certain chosen leaders did, behind the backs of the negotiating committee—which resigned as one man.

2015. Would you agree with me that they entered into an agreement, as the representatives of the profession?—No, Sir. I am sorry to fall out with a

respected member of this Commission, but that kind of thing is partly the reason why we exist—because the statements that you make are very strongly felt by us. It is false propaganda which is sent out, that the profession agreed to dilution and reduction of fees, and so on—it is entirely false. The profession has never been consulted by referendum or by meetings or anything. A few traitors have, behind the doors, allowed their committees to resign, and have run privately through the back door to the Minister and negotiated without consultation. That is what we call dirty work and not a professional agreement.

2016. And that is your view of the negotiations which resulted in the 1955 agreement?—We consider that as a fact and not as a view. When the Mansfield Committee, as one man, resigned because they would not accept the view of the Minister, we are told that Mr. Balding allowed their resignation and went through the back door and accepted the Minister's recommendations. There was no referendum to the profession.—*Mr. Brennan*: Mr. Chairman, as I was a delegate to the Dental Committee when the Minister's proposals were accepted, I think I have a right to say just a little bit about it. There is one thing—Sir Hugh Watson says it was accepted. The Remuneration Committee of the British Dental Association—which I think should have more say in the matter than any other committee on the British Dental Association—recommended unanimously that the Minister's proposals should be rejected. That is a statement that can be substantiated. Furthermore, the Minister's proposals were not heard of until the day preceding the conference of Local Dental Committees, the Local Dental Committees being the committees who really have the right to deal with that sort of matter. The Minister's proposals were lying on each of our chairs when we got there. We had absolutely no time to study them. It was simply rushed through without the profession having any chance to do much about it. So I do not think it can be said that the profession, at any rate, has accepted the proposals.

2017. *Sir David Hughes Parry*: Could I just help to solve the matter? You used the expression "they were rushed through". Is that right?—Yes, exactly.

2018. They were rushed through at the meeting; in other words the meeting did adopt them?—Under protest, and without time for due consideration.

2019. *Sir Hugh Watson*: Now may we turn to another matter, which was dealt with in your memorandum, under "Administration". I want to make it plain at the outset that actually administration is quite outside the terms of the remit of this Royal Commission; but you have laid some allegations here. It is not a matter in which we can interfere, but it has already been enquired into by the McNair Committee; and the McNair Committee, having gone into the matter of the Dental Estimates Board, which you are criticising here, said that they considered it served a good purpose. You are aware of that?—*Dr. Malik*: I am not aware that they made any enquiries generally from the general practitioners as to the conduct or administration of the Dental Estimates Board, no, Sir. I refer, of course, to the experience of our members, including myself.

2020. May I remind you that in paragraph 61 of the McNair Report, the Committee reported—and these are the words of responsible people—"We are satisfied that, as long as [dentists] are remunerated in this way"—that is, by an item of service method of payment—"the Dental Estimates Board provides an effective and necessary instrument both as a safeguard against abuse and to secure proper and prompt payment from public funds." If you will turn to the appendix, page 47, they went into this matter in some detail. They say "... we received evidence in writing and orally from the Board and, in addition, some of our members visited their offices at Eastbourne." And the Committee were left with two very strong impressions. The first was the efficiency of the Board and the second was that by far the greatest part of the Board's work is taken up with the examination and verification of estimates simply as claims for payment. That is what the McNair Committee said, and it is apparent from what they say that they went into this matter very closely.—May I point out paragraph 30 on page 11? They say there that they were disturbed to learn from the Dental Board that many of the general practitioners would be unwilling to advise any young person to

make dentistry his career. The general impression was that many general practitioners employed in general practice in the Health Service are dissatisfied. That is particularly regrettable as a contrast to the high morale that was understood to exist previously. They say, "Elsewhere, we consider in more detail the constituent parts and the causes of this dissatisfaction, but here we must say that so long as so many of the profession are dispirited and discontented, there will be a serious handicap in the way of recruitment."

2021. Dr. Malik, I was talking about the Dental Estimates Board and its functions.—The dissatisfaction is nine-tenths due to the handling of the profession by the Dental Estimates Board.

2022. But you see, the McNair Committee did not think that.—If that paragraph does not mean that, I fail to understand what language is.

2023. Sir David Hughes Parry: You obviously failed to understand the meaning of paragraph 30.—I have not discovered what you mean by it.

2024. Paragraph 30 has no condemnation whatsoever of the Dental Estimates Board.—I am not quite with you. I was saying that the Dental Estimates Board has created an atmosphere which is admittedly making dentists feel disgruntled.

2025. Sir Hugh Watson: What you are saying, is it not, is that the McNair Committee say that they got the general impression that dentists were dissatisfied with work in the National Health Service?—Yes.

2026. You then go on to say that, in your opinion, that is largely attributable to the way in which the Dental Estimates Board carries out its duty?—Yes, Sir; and the Government tries to impose fresh cuts, and so on.

2027. What I am pointing out to you is that the McNair Committee have gone thoroughly into it.—Mr. Daker: May I answer? I think we must accept, as regards the Dental Estimates Board, that it does its work efficiently. It is a necessary evil, as much as income tax. We find fault with income tax proposals and in the same way we must find fault with the administration of bodies such as the Dental Estimates Board—while acknowledging that it probably runs its affairs quite efficiently.

2028. Chairman: That is a very different statement from the one made in this memorandum of yours.—Yes.

2029. Which says that the Board causes a good deal of annoyance and grievance by apparently conceiving its duties as that of an agent for cutting down fees.—Dr. Malik: Yes, Sir. Now in the case of F. Boyle—I do not know if you are interested, but the documents are here—the fee prescribed in the scale was £12 10s. At the time those fees were subject to a 10 per cent. deduction, and since the scale had been drawn up the prices of material had gone up and technicians' fees had gone up, and the Dental Estimates Board had cut the claim down to a figure which would actually involve a loss of money by the dentist. He preferred to lose the patient than to carry out the duty. They insisted that he was bound by his terms of contract to carry on, on their terms. It cost the dentist 25 guineas to consult a well known counsel in order to establish his right that he was not compelled to accept the dictates of the Dental Estimates Board when they differed from his own judgment. He did establish that, but he lost the patient and he lost the money and he lost the time. That is the kind of thing that the Dental Estimates Board does—it does it time and time again, Sir. The papers are here, Sir.

2030. This is something supplementary to your evidence?—You wanted us to substantiate our remarks. The number is F. Boyle, AKCD 27/5, DCS/D8/43.

2031. What you are saying, Dr. Malik, is that there are cases in which a particular dentist and the Board do not agree as to what is the proper scale of fees?—It is not just a matter of a shilling or two; when the cuts are so continuous that there is a time when you are faced actually with a financial loss and you are told that you have got to proceed with the treatment, it sounds more like slavery than a civilised service, Sir. The power claimed by Eastbourne is just fantastic.—Mr. Barlow: Mr. Chairman, there is a paragraph in the Scale of Fees which says, on certain items, that the fee which will be or is to be approved is no figure at all, but is to be decided by the Board. In those circumstances, when we put in what we think is a fair figure, almost invariably we are given a lower one than the one we have put in. My experience has been

that when I have put in a certain figure that I really thought was fair, that I have not put any higher than it should be, knowing they would cut it, it is always cut. Then there is another aspect. For gold inlay, for instance, the figure is between one certain amount and another certain amount, to be decided by the Board. Well, knowing the work involved and the inlay and filling concerned, you put in what you think is a fair figure. I have found that it is always reduced when it comes back, and I think that is something which might throw a little light on the subject.—*Dr. Malik*: There is another case, Sir, which perhaps I might be allowed to mention—a case of ulcerative gingivitis, which is a very acute condition and very painful. In 1949 they decided that they would not call it an acute emergency case but they would class it as prolonged gum treatment, which gave them the power to make this particular work wait for prior approval. Obviously, the patient cannot wait five or six weeks for the gentlemen of Eastbourne, because his gums are bleeding and he is in pain; so in one particular case I deliberately broke the regulation and I asked the patient for his money first, and I informed the Board that was what I had done. I proceeded with the treatment and then asked them to refund the patient his money. I was on the mat, and the upshot of it was that the London Executive Council said that I was quite right and that the Minister ought to alter the regulation so as to give the dentist power to treat these emergency cases. But, of course, when there is anything in favour of the dentist, the Minister cannot hear it. The regulation is still standing as such—that you have to have approval to treat a very painful and very distressing condition.

2032. *Sir Hugh Watson*: Dr. Malik, you will pardon me, but I do not understand this. I have in front of me the Handbook for General Dental Practitioners, and on page 46 under Appendix 2 there are three columns. Column A is treatment which may be completed without obtaining the prior approval of the Board. One of the items is emergency treatment, and that is defined as treatment for the immediate relief of pain or other urgent symptoms.—But they do not accept ulcerative gingivitis as such. They have classed it as prolonged gum treatment and, as such, if

you stuck to the rules, you would have to wait till their approval arrives. In point of fact, I just say, "Treatment proceeding" and give a description. But I am actually not in order in carrying out the treatment because they insist that it must have prior approval. And that was the case—there is the file here if you want it, SID/45509 of the London Executive Council.

2033. Dr. Malik, you are aware, of course, that if a dentist considers that any decision of the Dental Estimates Board was unjust he has in fact the right of appeal to two dental colleagues, practitioners appointed by the Minister?—Yes, and unfortunately the people who are appointed by the Minister are not always in sympathy with the humble practitioner.

2034. One of them is a member of the panel, which is set up, is he not—one must be a member of a certain panel?—Nominated by the British Dental Association.

2035. I see. So that your view of the whole matter is that all the way along the cards are stacked against you?—Yes, Sir; there is no doubt about that.

2036. *Chairman*: There is no doubt that that is your view.—That is my considered view after ten years' experience.

2037. Yes, it is quite all right to say that that is your view, but it does not follow that it is a fact.—It is a fact in my life.

2038. *Mr. Watson*: Do you feel that conditions would be improved if the Dental Estimates Board were abolished?—No, I do not think, if I was in the position of re-organising the Service, that I would want the Dental Estimates Board abolished, because public money has to be looked after and you cannot be sure, even about an honest lot of dentists. But I do think a reasonable amount of play must be given, and reasonable freedom.

2039. Would you agree with Mr. Daker that it is an efficient board?—It depends what you mean by efficiency.

2040. Mr. Daker said that the Dental Estimates Board is an efficient Board.—It is efficient in the sense of carrying out what it conceives as its duty, but I think the concept is wrong.—*Mr. Barlow*: Might I say this—that it is an efficient Board and that it has improved considerably. But there have

been cases where there have been considerable delays in getting approval, and I have had one as long as two years, when the models were lost in the Board's area; before I got approval it actually took two years. By that time I had finished the work, fortunately, which was the straightening of some teeth for a child. That was in the early days admittedly, and things have improved; but I still find there are delays which necessitate us very often taking another lot of impressions, because a child's mouth alters very quickly. For that we are not allowed any extra of course, but we have to go through the performance of impressions and models all over again because a long time elapses before we get approval to go ahead, on an orthodontic case. There are other examples. Another point I would like to throw some light on is that I have sought redress on a point of ethics on more than one occasion by resorting to the tribunal which Sir Hugh Watson mentioned, to try and see if it would work. I have heard them say, "We are not in this for our health; we have come long distances but we do not get paid for this, you know". They gave their opinions as what I thought pseudo-judges that my complaints in one place were frivolous. That was not thought so by the persons representing I think, the Executive Council or the Dental Estimates Board, and I felt very strongly about it. But I tried several cases—which I can substantiate and bring forward in model form—and can prove to the hilt that they were thoroughly and properly ethical. I gave up in the end, because I thought it was a waste of everybody's time to do what I thought was ethical dentistry, as taught by my training hospital.

2041. *Sir Hugh Watson*: I think we understand your views about that. Dr. Malik, there is one statement which you make which certainly astonished me. You say that dentists have been fined hundreds of pounds for not sending in their completed forms within thirty days of completion.—*Dr. Malik*: Yes, Sir. The case is here.

2042. *Chairman*: I think you actually attribute that to the Dental Estimates Board.—Well, no; it is part and parcel of the policy of the ill treatment of the dentists by the Minister. There was another glaring case where the patient needed easing.

2043. What I am asking, Dr. Malik, is are you saying that this is the action of the Dental Estimates Board?—No, Sir. It is the Ministry in this case, mostly. The Dental Estimates Board report a case, which in this case is supposed to be a breach of regulations, and they check it with the Council, make out their case and make recommendations. Then the Minister finally passes judgment, very frequently doubling the penalty prescribed by the Executive Council.

2044. You say the Minister very frequently doubles the penalty?—In some cases, Sir.

2045. You said very frequently.—I know in one case he did, where the patient needed an easing. The patient refused to go back to his dentist, because the dentist had not given him ether, or something.

2046. *Sir Hugh Watson*: Could we stick to the case about the hundreds of pounds, in the meantime, and may I remind you that the procedure about these matters is that the matter, first of all, goes before the Executive Council?—Yes.

2047. It then goes to the Tribunal. Am I right?—I do not know what you mean by the Tribunal. That is the Executive Council.

2048. No, with respect it is not. There is a National Health Service Tribunal, is there not?—No, Sir.

2049. My information is that there is.—There is the Services Committee.

2050. But it is possible for a dentist, or any medical practitioner, who is aggrieved to appeal to the National Health Service Tribunal for England and Wales, which consists of two members appointed by the Minister, and a legally qualified chairman appointed by the Lord Chancellor.—Yes, Sir.

2051. You are aware of that?—Yes, Sir, I have had some experience of it.

2052. I thought you had just told me you had never heard of it.—There is a case I wanted to quote where the patient needed an easing, and the patient would not go to the dentist. The Ministry took away the whole of the fee for making the denture, because they said that, according to the regulations, he had not completed his terms of service.

Chairman: Would you please try and stick to answering Sir Hugh's question?

2053. *Sir Hugh Watson*: In point of fact, Dr. Malik, if a dentist is told by the Executive Council that he has to suffer some reduction of remuneration—because that is what you mean by a fine—he has an appeal to the Minister, has he not?—Yes.

2054. And, to deal with these appeals the Minister appoints two or three persons specially for the purpose, including a lawyer of standing?—Yes.

2055. So the Minister is advised by these people?—We do not consider that the people appointed are impartial. They would not stand on a jury, Sir.

2056. And you do not consider that the appointment as chairman of a neutral legal person is sufficient?—I do not think there is a neutral legal person in any of the whole set-up, Sir.

Sir Hugh Watson: Perhaps we need not pursue that matter.

2057. *Chairman*: We were going to have these instances. You still say, for instance, that dentists have been fined hundreds of pounds for not sending in their completed forms within 30 days of completion?—Yes, Sir. I have got the case here, Sir.

2058. You did say cases, but, still, you have got one case?—I have got one case. The total fine was £1,202 6s. 3d. in two years.

2059. And that was simply for not sending in . . . ?—Simply and solely for not sending the cases within 30 days of completion.

2060. And when were they sent in?—It was a case in Cardiff, Sir. It was approximately eighteen months to two years ago. It was printed in a circular of ours, and it was reprinted from a publication known as "The Executive Council". But I have got a verification of it from the Executive Council and the Registrar of the General Dental Council. I have got the document here.

2061. And you are saying that this dentist would be receiving £1,200 more than he got, if he had sent in his forms within 30 days?—He would not have been the loser of £1,202 6s. 3d. in two years.

2062. He would have had that much more, if he had sent in certain papers . . . ?— . . . within 30 days.

2063. And when did he send them in, within 40 days or what?—I would not know the exact dates, but it was more than 30 days.

2064. *Sir Hugh Watson*: How many days more?—I could not say, Sir, but the documents are here if you wish to see them.

2065. *Chairman*: But the documents do not disclose that fact?—No, Sir. There is some kind of code that you must not advertise names of persons, and they do not say exactly.

2066. No, the question was how much longer.—I should think it might have been a few weeks, from a reading of it. Would you like me to read the whole lot, Sir?

Chairman: No.

2067. *Sir Hugh Watson*: Tell me this, Dr. Malik. From what you said a moment ago, could you tell me if that was relating to one incident, or a whole series of incidents?—I think that the man had done it before, yes.

2068. In other words, this fine, as you describe it, of £1,202 did not relate only to one incident?—No, Sir.

2069. How many incidents did it relate to?—I would not know but, supposing that it was a thousand, what crime is there if, through being very busy, you forget to fill the forms in within 30 days or a week, or whatever it is? The point is that there is no allegation that the work claimed for was falsely claimed. There were no fraud allegations. It was purely and simply a question of date, and I think it is very unjust, Sir, to be fined heavy sums for merely a date.

Sir Hugh Watson: Do you wish to have these papers, Sir?

Chairman: I think we had better have them.

2070. *Sir Hugh Watson*: Are you prepared to let the Commission have these papers, Dr. Malik?—Yes, of course. (Papers passed to the Commission.)

2071. *Mr. Watson*: Did the local Dental Services Committee of the Executive Council support the facts?—Yes, Sir. Being a Royal Commission you would probably have names and places, which I cannot disclose.

2072. I think you must have misunderstood my question. Did the local Dental

Services Committee of the Executive Council uphold the finding, or the withholding of the fees, in this case?—Yes, they worked to rule and ordered certain fines; and I believe they were increased by the Minister, but I would not be quite sure. The facts are all there.

2073. So whatever was imposed upon this Mr. X dentist, it was with the support of his fellow dentists?—No, Sir. The local Services Committee consists of about 18 to 20 people and only 2 of them are dentists.

2074. *Chairman*: Actually, since you have given me this form, I think I must read out one part of it, Dr. Malik. It says:

"By altering the dates of treatment on 53 of these forms and falsely represented that the forms were submitted within the prescribed time limit."

—Yes. I suppose the fellow got so frightened that he would be fined again that he altered the date, but it is all about the date, Sir. There is no question of claiming falsely any money for which he had not worked. It was all a question of dates. If you threatened me enough, I should imagine I would say the same and rub out the dates.

2075. *Sir Hugh Watson*: Can we turn to another matter, to which you attach importance, the question of ancillaries? This question of ancillaries has been gone into by various bodies in the past, as you are probably aware. You know that the Teviot Committee looked into this matter, and you know that the Teviot Committee recommended that a general scheme for the training of dental hygienists should be initiated forthwith. You know that the McNair Committee investigated the question of ancillaries, as you call them, and you know that they reported in paragraph 105 that the opinion of the profession is that their work is valuable?—May I correct you, Sir, on one word? I think that we are at cross-purposes as to the meaning of the thing we are talking about. You are using the word "ancillary" as meaning people who do scaling.

2076. No.—But the Teviot Committee never mentioned the word ancillary.

2077. I was using the word ancillary which, as you are aware, comes under

two categories. First, there are dental hygienists who do scaling, and so on. There is another form, with which I shall deal in a moment, but at the moment I am dealing with what the Teviot Committee and the McNair Committee said about the oral hygienists.—We have no objection to the oral hygienists, because they do scaling, and have always been legal.

2078. The next type of ancillary is what is known as ancillary dental workers. Are you familiar with them?—No, Sir. I happen to be on the Committee which is in charge of this so-called experiment, and we have now decided to call them auxiliaries. So operative auxiliaries are different from ancillaries; that is to say, people who do fillings, and take teeth out. They are the curse of the profession.

2079. You call them auxiliaries?—Yes, Sir.

2080. Then we will call them auxiliaries. In the first place, am I right in understanding that, at the moment, an experiment is being carried out, at the initiation of the Privy Council, in order to decide whether these people should be licensed?—Yes, Sir.

2081. Until that experiment has been concluded, nothing further will be done. Is that right?—That is the theory of it, yes, Sir.

2082. If the experiment is concluded and is regarded as being satisfactory, nothing can be done until the resulting regulations receive the approval of both Houses of Parliament?—That is so, in theory.

2083. That is a fact, is it not, Dr. Malik? These are the safeguards which Parliament has laid down for the introduction of this form of practice, is it not?—I do not know whether you want me to speak as a sort of Hyde Park speaker, or give the facts as we know them from behind the scenes. The experiment so-called is already decided, by the majority of the people who matter, that it is going to be successful.

2084. We will assume that it is so. It cannot be put into operation until the thing has received the approval of both Houses of Parliament?—Quite so, and they are guided by these very people.

2085. And, furthermore, assuming that it does receive the approval of both Houses of Parliament, these people will

only he allowed to be employed in hospitals and clinics. Am I right?—I could not say, because the regulation is not yet made.

2086. But that is what is provided in the Act, is it not?—They are not to be confined, no, because the original regulation about the hygienists was that they should be confined to hospitals and public authorities. When the General Dental Council decided that that should be so the Minister wrote a letter to us—the General Dental Council—to say that we would have to reverse our decision, and we did under protest. Now the hygienists are allowed in private practice, and there is no question about it that the Ministry, if it thought that it would serve its purpose to ditch the dentists, would make a similar regulation. There is no question about the Ministry threatening us in the case of the hygienists. They did do so.

2087. As you are aware, Section 19 (2) of the Act of 1956 directs specifically that the regulations which are to be made shall be so framed as to secure that dental work of the kind you are talking about, carried out by an ancillary worker, must be carried out under the supervision of a dentist.—Yes, but you could have the supervision, I suppose, in your surgery. It does not exclude such employment, does it? But that is beside the point, Sir. Actually, I think it would be more harmful to the profession, as we know it today, if they were to flood the so-called health centres with auxiliaries, and if thousands of the health centres were to be established, with one dentist, to satisfy the law, who was said to be supervising these people. All the population would be forced into these health centres, and the private practitioner could sit and twiddle his thumbs, or do road sweeping.

2088. *Mr. Watson*: Road sweeping is an honourable occupation, Dr. Malik.—I have no doubt, but it is not the same as oral hygiene.

2089. *Sir Hugh Watson*: You touched on the question of recruitment, and you have said that the McNair Report admits that dentists are not recommending their sons and daughters to enter the profession. I do not read the report in the way that you do.—I quoted paragraph 30, Sir, of the McNair Report, which says definitely . . .

2090. It does not mention sons and daughters, Dr. Malik.—“We were disturbed to learn from the Dental Board, the British Dental Association, and many of the dental witnesses that the majority of dentists in general practice would be unwilling to advise any young person to make dentistry his career.” If he would not allow outsiders to do so, he would not allow his children.

2091. Would you look at paragraph 59, which begins: “We know that as compared with other professions, in dentistry a relatively high proportion of sons succeed their fathers, and we note that some 10 per cent. of the dental students at present in the schools are, in fact, the relatives of dentists.” Then they go on to give reasons for this.—Yes, but I do not know if it is a fact or not. You can have your misgivings about advising your sons and daughters, but if they have taken it into their heads, you are not going to fight them.

2092. But that applies to any profession today, does it not?—Yes, but the point we made was that, owing to the dissatisfaction, they have got their misgivings about advising anybody, including their sons and daughters.—*Mr. Barlow*: I would not put my son into the profession, in the present state of affairs. I can substantiate it that far, and I would say that the numbers—although, perhaps there were more coming in via the sons and daughters of the dentists—are much less today because of this. Also, in 1956 I think I am right in saying the recruitment per annum was hundreds less than in previous years, and I think, therefore, you can claim that the high proportion who came in via the offspring of dentists was equally reduced.

2093. There is no information about that, Mr. Barlow.—Yes, Sir, there are statistics. I can provide statistics to that effect. The recruitment is known by the Dentists Register, and it dropped by hundreds in 1956.

2094. *Mr. Watson*: Have you evidence of dentists' sons who are earning higher sums under the age of 30, as you have submitted in your memorandum?

Chairman: That is dentists' sons in other occupations.

Mr. Watson: For instance, Dr. Malik is making the point that sons are not following their fathers into their profession.—Yes.

2095. Have you any evidence as an association that the sons of your members, who are working outside the dental profession and are under 30, are earning as much as dentists who are under 30?—Do you mean that dental men change their jobs?

2096. No. Can you tell me the salaries that dentists' sons are earning in any other profession, outside dentistry?—Yes, I could give you quite a few.—*Dr. Malik*: I think I know the gist of the point. It is a very good thing for a young man under 30 to make very big sums, but, unfortunately, the prospects in a dental career are bad from two points. One is that, assuming the conditions to remain as they are today, his earnings will gradually go down because his speed will go down with age; the other is that in about ten to fifteen years time he will not be wanted, anyway, because the auxiliaries will fill the health centres, and the Ministry will say "We are not going to pay an outside dentist to do work for us, when we can get it done by a girl working for £6 or £7 a week." So that our prospects, especially for the young dentists, are bleak, indeed.—*Mr. Barlow*: May I just add to that that I think there are many—and I can substantiate it—sons of dentists who are earning a great deal more outside dentistry. Any amount of young men who are in dentistry have told me that, even at the age of 30, they have to work evenings as well, and are really dog tired by what they are doing.—*Mr. Brennan*: May I elaborate on that Mr. Chairman, regarding this question of people earning more in other professions, outside the dental profession, and that sort of thing.

2097. What is the point you wanted to make?—The point I wanted to make is this. In the first place—not that I think it is proof—I have two sons, neither of whom would dream of going into the dental profession. One of them is a biological chemist, the other one has a jewellery business. That is no evidence, but it is just a supporting suggestion. But the point is that, with regard to what you earn in another profession, there are such a lot of things that enter into that. In the first place, I do not agree that the method of finding out what the dentists are alleged to earn is a correct method. It gives a bare statement of what they, in fact, do earn.

2098. Are you saying, Mr. Brennan, that the Economist Intelligence Unit reported wrongly?—No, I am speaking generally.

2099. Are you saying that that report is right or wrong?—If I may appear to disagree with my Association, I would say that that report covers not a sufficient number to really be representative. But the point is this. When we come down to the question of earnings, we have got several things to consider. In my opinion, the whole system of determining what a dentist earns is wrong. It is incorrect. It does not give a true picture. In the second place, you have got to take into consideration not only what a man earns, but the number of hours that he has to work. In the third place, you have got to take into consideration not only the number of hours that he works, but the hours at which he works them. In any other occupation, in industry and that sort of thing, if a man works on a Sunday morning or a Saturday afternoon, or late at night, he gets overtime. In the dental profession he does not. There is one thing that we must consider about the dental profession, from the point of view of the public and the point of view of time. We know that some of us are very, very busy in certain areas where there is a shortage of dentists, but that does not apply to every area. In some areas there are a number of dentists with very few patients. It is not equally divided. There are no approved areas in the dental profession, as there are in the medical profession. The working man either has to lose time to get in during the daytime, or he has to go after hours, after his own working hours, on his half-day or possibly on a Sunday. In the ordinary way, if a working man wants to go to a doctor or an optician, or something like that, he asks for an hour off. He loses an hour and that is O.K. But when a patient comes in for a course of dental treatment he may come in as many as twenty times. He has got to take off an hour twenty times. Consequently, he will only be prepared to come in in the evening. The point is that a dentist has to work far later. I know dentists who work up until 10 o'clock at night, and I am not exaggerating. I also know dentists who work on Saturday afternoons and Sundays. There is another point. Not only does he not get overtime for that work, but

he is immediately up against staff difficulties. You cannot get a dental nurse to work after 6 o'clock; most of them want to go at half past five.

2100. I do not want to interrupt you, but do not give us a complete account of the dentist's work. I do not think we need all that. Try and keep to the point which was really under discussion.—I simply come back to the point that it is not a bit of good talking about what a dentist earns, whether it is in comparison with other professions or not. It is a question of the hours he has got to put in to earn that money, and there is very little evidence to prove what hours a dentist actually does put in. Also, there is the question of overtime and the time at which he does earn it.

2101. The Commission has had a very full statement of your views, separately, Mr. Brennan, has it not?—Yes.

2102. *Mr. Bonham-Carter*: Do you seriously think, Mr. Brennan, that the equivalent of the dentist in industry is paid overtime?—I do not know about any industry. I think that anybody working overtime, as a general rule, in 98 per cent. of the cases in this country, gets paid overtime.

2103. Do you think management is paid overtime?—I do not know that, but the staff of the Estimates Board are, for instance.—*Mrs. Thorburn*: May I say that people may get overtime, but that is nothing to do with the fact that whatever the conditions are you have to pay out your overhead expenses, whether you are ill, or whether or not you are actually working. In industry a man who is employed does not necessarily have to do that. He only has his salary, and, although he may not be paid extra for working overtime, we have to pay all our costs as well, which is never really considered sufficiently, I think.

2104. *Sir Hugh Watson*: That is common to all professions, is it not?—A doctor receives a capitation fee. He always knows roughly what he will get, but we have to pay out something. The income tax people give us something like 52 per cent., but it really is more like 60 per cent. with our overheads and costs.

2105. But all professions have to bear their overheads, do they not?—Yes, but the doctor gets paid whether he sees a person or does not. We only get

paid if a patient comes to us. Supposing there is a strike or a fog, or something like that. We do not necessarily have any work to do and, consequently, we lose money, but we have our overheads just the same.

2106. I do not know where this is taking us, but that would apply even if there were not a National Health Service, would it not? If there were a fog or a strike people would not be able to go to the dentist, anyway.—No, but before that, when we had private patients, we could make up for that. We had a little bit extra behind us to deal with those contingencies. Today we have not got that, because we are not paid sufficiently.

2107. *Chairman*: Are you recommending a change from the item of service basis of payment, to a capitation fee basis?—I think it should be considered, in view of the fact of our own dissatisfaction with the present conditions. I think something should be done to alter what is obviously not working terribly well.

2108. *Sir David Hughes Parry*: A salaried service . . . ?—That may be considered, too. I think that may be our solution. I do not know, but I think it should be considered, because we are not satisfied.

2109. *Sir Hugh Watson*: Are you representing the policy of your Association?—*Dr. Malik*: No, Sir. We have not considered that.

2110. *Chairman*: You have no suggestion to make about a new system?—No, Sir. I believe that, at the moment, the profession as a whole prefers the itemised scale, but each individual has his own ideas. But I believe there have been discreet enquiries here and there, and the majority prefer the present system.

2111. The item of service system?—Yes.—*Mr. Barlow*: What I wanted to say, Sir Hugh, was that I think it is quite true, of course, that we all have our overhead expenses and we all suffer equally. But I do think that our overhead expenses are considerably more than doctors', because we have a mechanical department, and we have an office department to deal with the administrative work which we have to tackle. Actually, I do it after hours to try and save money and staff. We also

have to have a receptionist, and it is very good to have a chairside assistant to try and do more work. Therefore, the rate at which we have to work gets more during the day. We are becoming faster automatons in the chair, and from 4,300 revolutions per minute for dental drills we are going up shortly, I think, to a quarter of a million revolutions.

2112. *Sir Hugh Watson*: That, of course, is recognised, because the ratio of a doctor's expenses is a third, and yours is of the order of 48 or 52 per cent., whichever is the reigning figure at the moment.—And on that basis I think we must have more remuneration than the doctors, to offset the greater expense of our overheads.

2113. *Chairman*: More gross remuneration?—More gross remuneration.

2114. But has that ever been questioned, Mr. Barlow?—I thought it was being so, but perhaps I misunderstood.

2115. The percentage expenses, as Sir Hugh said, is admitted in the case of the dentists to be considerably higher than that of the doctors, and the amount is grossed upon a net figure. Is that not right?—Yes, I think that is so, but I found it really more than the agreed one of, I think, 52 per cent. I am quite sure it is nearer 62 or 65, from my own figures.

2116. *Sir Hugh Watson*: But this unevenness happens in the medical profession, too. We have had evidence of doctors who spend as much as 60 per cent. on their own practice, but that is their own business. They only want to be efficient.—I economise in all the ways I can imagine. In fact, I save £25 a year by using oil heaters throughout my building, instead of electrical apparatus, and I have followed that principle of economy throughout until I have got to the end. Now there are no more economies I can effect.

2117. Can we turn to another subject? In your memorandum on page 366 you make the statement that the profession has been the subject of some false propaganda on the part of the Ministry. What do you mean by that?—*Dr. Malik*: It is not so long ago that the headlines said "Dentist earns £12,000. Dentist earns £15,000." Also, in other inspired articles in the common press you get the insinuation that dentists are really in the money.

2118. But in your statement here, you talk about false propaganda on the part of the Ministry. Now you are talking about articles in the public press.—And they all emanated from Parliament, in the first place.

2119. Parliament is not the Ministry.—Is not the Minister of Health the Ministry, Sir?

2120. You say here: "False propaganda on the part of the Ministry". You instance articles in the public press.—Inspired by them.

2121. Inspired by whom?—By the Ministry.

2122. How do you know?—Because of my experience in the way these articles are arrived at. One day the Sunday Express man comes along and says "Can I have the low-down on this?" And then I hear that the same chap has been to all sorts of places, Hill Street, Whitehall and so on. And then in three weeks time not the Sunday Express but the News of the World publishes an article on dentistry, and part of the facts which have come from me appear there.

2123. So you base your allegation that the profession has been the subject of false propaganda on the part of the Ministry on articles which have appeared in the Sunday Express and the News of the World?—That is putting it in a grotesque way.

2124. That is what you said to me.—But it is partly true. But also, if you look at Hansard, for instance, you will find that Mr. Bevan, when he was Minister at the time when Dame Enid Russell-Smith wrote this letter dated 3rd December, 1948, was alleging the earnings of the dentists to be something like £12,000 a year, when, in point of fact, they are often 52 per cent. less than that. Also, it should have been pointed out that the person who might be earning it had several assistants, and was working a terrific number of hours.

2125. *Chairman*: What are you quoting from?—I am quoting from a letter written by Dame Enid Russell-Smith on the 3rd December, 1948, addressed to the Secretary of the British Dental Association, 13, Hill Street, Berkeley Square, justifying the interim order which restricted the earnings of dentists to £400 a month.

2126. *Sir Hugh Watson*: Was that the effect of the order, Dr. Malik?—That was the effect of it, yes.

2127. Was it?—Yes.

2128. Are you certain?—At the time, yes.

2129. My recollection was that it reduced by 50 per cent. the earnings of dentists above the level of £400 a month.—In point of fact, we never got what was quoted there.

2130. It reduced by 50 per cent. the earnings of dentists over £400 a month. That is not what you said.—I am sorry, but it restricted the earnings to £400 a month, and above that dentists were paid at only half rate, because at the time it was thought the half was out of pocket. So that it was, in point of fact, abolishing the earnings of the dentists altogether, because if the gross earnings were £100 and the dentist got only £50 he did not make a single penny on it.

2131. We are still trying to find evidence of false propaganda on the part of the Ministry, Dr. Malik.—I was quoting the Ministry in the shape of Dame Enid Russell-Smith, who falsely stated in Parliament that so many dentists were earning so much when, in point of fact, that same figure was a gross figure and not a net figure, and there were no references to the fact that that person might have had several assistants, and might have been working double time.

2132. You have Hansard there, have you? You are quoting from Hansard, are you?—This is an actual copy of a letter written by Dame Enid Russell-Smith to the Secretary of the B.D.A. dated 3rd December, 1948.

2133. But, Dr. Malik, you said just now that you were referring to what took place in Parliament.—I have got it somewhere in a speech by the Minister of Health.

2134. Let us get this quite clear. I want to have evidence of this alleged false propaganda by the Ministry. You began by making a reference to Mr. Bevan. Now you are making a reference to Dame Enid Russell-Smith. Would you please expand these two matters separately? What did Mr. Bevan say and where and when?—You have got me there. I can tell you that it was in Parliament. It was round about 1948. I think Mr. Barlow has got it.—Mr.

Barlow: No, I have not got it here, but I have got press cuttings to the effect that the Minister said we were all extremely happy and the Health Service was working marvellously, which was grossly untrue. I have got a cutting to that effect, which was put forward to the press by the Minister of Health.

2135. Was that stated in Parliament by the Minister?—I think it was handed out to the press, but I do not know if it was stated in Parliament.—*Dr. Malik*: But the Minister at the time did say—I have got it somewhere, and I can produce it at a given time—that it was necessary for a new regulation to be made, because dentists were earning so-and-so, and it was exactly on the lines of this letter which I have got in my hand. I can produce that. I can produce it if you give me sufficient time.

2136. *Chairman*: It is that that you mean when you say that the profession has been subject to some false propaganda on the part of the Ministry. . . . and we are strongly of the opinion that the Government regards the Dental Service as a vote-catching machine, rather than a Dental Service to the population." That is what you mean, is it?—Yes, that is what we mean. I mean that they are trying to show that we are making a lot of money by little work, when, in point of fact, they know that the opposite is true.

2137. What you are saying is that ten years ago there was one statement in Parliament, and one letter by Dame Enid, that you consider here that interpretation?—No, Sir, I would not say just one. I say that every time there is a new regulation statements are made in Parliament and in the press, sometimes acknowledged and sometimes not, to the effect that the dentists are earning money, the dentists are asking for this, and the dentists will agree to that, and when you trace them you find that they are not true.

2138. You know that we will, of course, be seeing the Ministry of Health in due course?—Yes. Dr. Senior did say that he was sorry he would not be here, because he has gone out of the country.

2139. And you have seen the factual memorandum by the Ministry of Health and the Department of Health for Scotland—this document?—No, Sir.

2140. It can be obtained from the Stationery Office. I am surprised you have not seen it, because it contains most of the facts on which we have so far been basing ourselves. But if you have not seen it there is no point in my asking whether you challenge any of the facts, and if you consider that that is false propaganda, too. It has been published for some months.—*Mr. Barlow*: I can produce various newspaper articles, from various sections of the press, which state that we are all very happy and the scheme is working very well. I have never yet come across anything issued from the Ministry to the effect that we are dissatisfied. All expressions of dissatisfaction have come from us, and those I can bring forward and put before you. There are statements by spokesmen from the Ministry, and various press articles.

2141. *Sir Hugh Watson*: Are you saying that spokesmen from the Ministry have contributed articles to the popular press?—They have given forth statements to the press to the effect that we are all happy and the scheme is working very well.

2142. *Chairman*: I was not quite sure whether you said they have given forth statements, or false statements.—I said forth statements, and those statements have all been that we are very happy. But that has not been the case.

2143. *Mr. Watson*: Suppose the press tomorrow report some of the indelicate language that has been used here this morning. Would you call that false propaganda?—I would deprecate it, Sir.

2144. *Sir Hugh Watson*: At the end of your paper, Dr. Malik, you make various recommendations, and the first one is with regard to remuneration. Do you suggest that the higher remuneration should be determined solely by reference to the age of dentists?—*Dr. Malik*: I feel, Sir, that there should be some method whereby experience should be rewarded, as against speed, because it seems to be quite contrary to the usual usage. When you go as a clerk to the L.C.C. you start at a certain figure, and you finish at a higher figure, towards the end of your career, when retirement age approaches. But with dentists the reverse is apparently going to be the case. You begin at 24 with £3,000 or

£4,000 net, and you finish up with £200 or £300.

2145. *Sir Hugh Watson*: That has always been a difficulty in dentistry, has it not, whether under the National Health Service or not?—I would not know, but I was under the impression that as you got on you got a number of people who believed in your skill, and they were willing to travel big distances and pay high fees, so that although your practice fell off in numbers your income became more, because you increased your fees and you selected your patients, your faithful followers.

2146. That would apply to a certain number of patients, but in these days of high taxation its application might be very limited, might it not?—I cannot dispute that. Your word is as good as mine, and mine is as good as yours.

2147. *Chairman*: Would there have been many dentists in the old days, who were really getting visits from patients long distances away and being paid high fees, or would that only have been a fairly small minority of what you might call the West End practitioners of towns and cities?—It would be very difficult to answer that, Sir, because every dentist you happen to meet will tell you over a cup of tea that he has had a patient from such-and-such a distance for so many years.—*Mr. Barlow*: I have patients who attend on me—I am in Cirencester in Gloucestershire—from Ireland, from St. Albans, from London, from Bournemouth and from Ascot, and I can go on. They come to me from various places, and for some reason they do not want to change. That does happen.

2148. I am not doubting that it has happened a lot and still happens.—That is my experience.

2149. *Sir Hugh Watson*: That is because a dentist has to work on a conscious and apprehensive patient.—Yes.

2150. Regarding the Spens Report, Dr. Malik, do you think that that Report implies that dentists should have automatic adjustments of remuneration, in accordance with movements in the cost of living?—*Dr. Malik*: Yes, I do, Sir. It was, in fact, accepted by the Government when the Medical Guild, much to its credit, compelled the Government to implement that by Act of Parliament.

The Minister today has no power to alter the conditions of service and remuneration of the doctors, hut, of course, being weak the dental profession is at the mercy of the Ministry, who take advantage of that. They just sit down and write an order.

2151. But on what do you found yourself, when you say that the doctors have their remuneration—which is what I understand you to say—fixed in accordance with the cost of living?—No, in accordance with the Spens Report, which was more or less a separate Act, as I understand it, compelling the Minister not to have the power to alter the conditions of service. As I understand it the Danckwerts award was based on that fact, that the Minister was paying something or other, which the B.M.A. thought was not in accordance with the Spens Report, and the Danckwerts award was a consequence of that.

2152. I think we had better get this clear. The Spens Committee recommended what they thought doctors ought to receive, in terms of the 1939 value of money. They left it to others to adjust that to the present time. The Government fixed a betterment of 20 per cent. in 1948, and that was agreed to by the profession. The profession then raised the question of a further betterment, and that matter was referred in 1952 to Mr. Justice Danckwerts on an agreed reference.—Yes.

2153. In the course of that reference. . . —But not without the B.M.A. first collecting 20,000 resignation forms, of which I had one.

2154. That matter was referred to Mr. Justice Danckwerts and, in the course of the reference Mr. Justice Danckwerts raised the point that he might have to deal with the years prior to 1950-51; counsel for the Government conceded that he would have to. Accordingly Mr. Justice Danckwerts fixed a betterment of 100 per cent. for the year 1952, and 80 per cent. for the two previous years, and there the matter has stood ever since. Is that the position?—So far as I understand it, yes, and now they say that you have got to adjust it again, because the cost of living has gone up.

2155. They are now seeking another adjustment, hut you started off by saying that there was an Act of Parliament which made the Government keep the

remuneration of doctors in line with the cost of living. That is not so.—In some way or other doctors have received the full benefit of the Spens Report, which we have not. Is that a fact? Do you agree to that?

2156. No, Sir. If you will allow me to say so, this is precisely why this Royal Commission has been set up, because the doctors maintain the very contrary. And it is that question as to who ought to be where, if I may say so, which this Royal Commission is investigating.—Perhaps I did not put my answer correctly. I was saying that up to 1952, up to the time when the Danckwerts award was made, the facts were that the B.M.A. and the Government came to an agreement that the conditions and the remuneration were not in keeping with the Spens Report. At the moment, the trouble is that the Government says "You are not entitled to a further adjustment because of the cost of living" and the medical men say "We are".

2157. With great respect, the Government have not said that at all. The Government have set up this Royal Commission to determine what is the proper remuneration for doctors, and, incidentally, dentists in the National Health Service.—Yes.

2158. I have another small point. On page 367 you mention that the cost of dental training is £2,500. Can you tell me how you arrive at that figure?—Approximately £500 a year or more would be needed for the student to live on, although we have not allowed enough for that, actually, for five years. That is your £2,500, but there is an addition for fees, books, examinations and hospital fees. Actually, that figure is a considerable understatement, is it not?

2159. You think that a student is entitled to £500 a year to live on?—I should say that today it would hardly be enough for fares, lunches and things like that. Actually, in that figure we have been very moderate. I do not forget that during the time he is studying, and earning nothing he would, if he were not going to train into a profession, be earning some money.

2160. That applies to all professional people, does it not?—That is true. We are not making a point of that.

Sir Hugh Watson: And, also, there are a number of substantial grants available for the training and education of dental and other students.

2161. *Sir David Hughes Parry:* Who pays the £2,500?—Probably the parent.

2162. Of what percentage?—I should imagine about 90 per cent., because the scholarships that you can get, which allow for maintenance, are very few. Even if they get a county grant it only pays for the fees.

2163. Do you know that nearly 80 per cent. of the undergraduates at Oxford and Cambridge get grants from local authorities, and from Government and trade sources?—For maintenance?

2164. Yes.—That is not applicable to the average dental student, you know.

2165. *Sir Hugh Watson:* Are you sure of that?—*Mr. Barlow:* I do not think it is the same as that in dentistry.

2166. Are you sure of that?—I am not.

2167. I suggest to you that it is the same, and that precisely the same grants are available for the dental schools, as are available for the universities.—*Dr. Malik:* I would disagree with that. Are you sure of yourself?

Sir Hugh Watson: Yes.

2168. *Chairman:* Dr. Malik, you are not asking the Commission questions.—I am so sorry.

2169. *Sir David Hughes Parry:* The University Grants Committee every year gives a full report on this matter, and indicates how many students at the different universities obtained grants. I think you ought to have a look at that.—I would love to. Where do I get it?

2170. The University Grants Committee Annual Report.—Where can we buy it?

Sir David Hughes Parry: The Stationery Office.

2171. *Chairman:* The Stationery Office is the place, and the Stationery Office is where I think you will get this Factual Memorandum by the Ministry of Health and the Department of Health for Scotland to the Royal Commission on Doctors' and Dentists' Remuneration.—I am sorry, we have not seen it.

2172. *Mr. Watson:* I would just like to ask one question. Dr. Malik, you

said some little while ago that if you were in a similar position to the dentist who altered the dates on the forms, you would also alter the dates on your forms.—I know. I said if you threatened me enough.

2173. Do you suggest that any dentist, who is unethical enough to alter dates, should be employed in the National Health Service?—I do not see very much wrong with altering dates under duress, Sir. I consider that altering facts and dates are quite different. If I claim a shilling more for doing something I have not done, I am a criminal, but if I say that the thing happened on the 3rd April, instead of on the 10th, I have committed no crime. Is that not the fact?

2174. *Chairman:* Dr. Malik, we have heard your point of view on that.—*Mr. Barlow:* I would like to say that I do not associate myself with that at all, and I do not think other members here do. I would consider it forgery, and quite wrong.

2175. Thank you very much. I am glad that that statement has been made.—*Mr. Brennan:* While we are on the question of penalties, I do not know whether I may come back to it?

2176. What is it you want to say?—I have been on the Brighton Executive Council for a number of years, and I think I can speak about penalties and fines. I think it would be of use to elucidate the thing a little bit, because it has not been put very clearly, if it has been put at all. The point is that, in the first place, there are two types of things that you might call penalties. Under certain circumstances, a dentist may just have his fee withheld; he simply does not get anything for the work that he has done, because it has not been considered that it was done properly. Then, on the other hand, you have definite penalties which are really fines. Those fines can be very, very high. It has been stated, and it is a thing which I agree with, that those fines are considerably higher than you would get in any court of law. I mean, a man can be fined up to £1,000, or something of that sort. This is a matter which in substance is quite right, but there are certain things that the layman can never quite understand. For one thing, for instance, you have the case where a filling has been charted for payment where, in fact, no filling has been done. On the

face of that, it appears to be definite fraud, does it not? It appears to be a definite attempt to claim money for work which has not been done. But what must be remembered is this, that forms are very, very difficult and very, very complicated. It is very, very easy to make a mistake and, furthermore, the average dentist just has not the time to fill in forms. He has to give that sort of thing to his nurse or secretary . . .

2177. *Sir Hugh Watson*: I find it very difficult to believe that, however complicated the form, a dentist can fill it up to the effect that he has made a filling when, in fact, he has not made a filling. —I think this is a thing which any dentist will support me in. It is very, very easy to make a mistake. But that is not my main point.

2178. *Chairman*: Could you give us your main point, quite shortly?—I must lead up to it. The point that I have always objected to, and the point that I have raised in the Executive Council on several occasions—and this applies not only to the dental side but to the ophthalmic and other services—is that it is almost an invariable habit of Executive Councils to have a system of increasing fines. If a man comes up once he gets a caution—that is usual. If he comes up again he gets a reprimand, if he comes up again he gets a small fine, and if he comes up again he gets a bigger fine. The point is this, that that system would be all right provided all the offences were the same. If it is a question of definite fraud then that is one matter, but if it is a question of just a slip-up, not quite keeping to regulations, and that sort of thing . . .

2179. *Sir Hugh Watson*: A little matter of altering dates, perhaps?—No, I do not agree with that. I will not

uphold that at all. I think a man should not alter dates. I certainly would not myself.

2180. *Chairman*: I do not want to interrupt, Mr. Brennan, but I think we can get this particular aspect out of the memorandum you submitted to us earlier. Dr. Malik, I do not think that the main request to this Commission is that we should base our recommendations about dentists' remuneration on what happens with fines and penalties for misdemeanours, is it?—*Dr. Malik*: No, Sir. The submission is that there is a wrong concept, and that you should recommend a different concept. The control from Eastbourne is necessary, but they should not go out of their way to administer the law in a punitive sense, or in a paltry sense which is not associated with facts, causing disagreements which we have mentioned, and cases such as we are referring to. It is purely psychological. The machinery is necessary, but where fines are too much I think that an appeal should be allowed in an ordinary court, and not to the Minister.

2181. I think we have finished hearing all that we wish to from you. You have made a good many statements today that are a bit wild, Dr. Malik, which may well be challenged and which you must expect to have challenged vigorously by other bodies, because some of them have not seemed to me to be supported very thoroughly by facts. But thank you, all the same, for submitting us your memorandum and for coming and giving us evidence this morning. That concludes the evidence.—Do you wish me to leave these documents? You will probably send them back.

Chairman: Yes, if you will kindly do that.

(The witnesses withdrew.)

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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

9

Ninth Day, Thursday, 20th February, 1958

WITNESSES

General Practice Reform Association

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

NINTH DAY

Thursday, 20th February, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MR. A. D. BONHAM-CARTER, T.D.

MR. I. D. MCINTOSH, M.A.

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

SIR DAVID HUGHES PARRY, Q.C.

PROFESSOR J. JEWKES, C.B.E.

SIR HUGH WATSON, D.K.S.

MR. S. WATSON, C.B.E.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

**Memorandum of Evidence from the Executive Committee of the General Practice
Reform Association to the Royal Commission on Doctors' and
Dentists' Remuneration**

REMUNERATION OF GENERAL PRACTITIONER PRINCIPALS

I

BACKGROUND TO THE REMUNERATION PROBLEM

The present system of payment based on the number of patients registered with a practitioner, up to a maximum of 3,500, or 5,500 where an assistant is employed, has in our opinion a number of grave disadvantages, which concern the distribution of work, the utilisation of medical man-power, standards of practice, and entry into practice.

The maximum permitted number of patients per practitioner is in our opinion greatly in excess of the number for which a doctor has the time to provide the full and proper range of general medical care, both preventive and therapeutic. Nevertheless, the level of remuneration being worked out on the basis of a maximum list of 3,500, it is in the financial interests of all practitioners to collect as many patients on their lists as they can get, irrespective of their ability to look after them. Many would prefer to have substantially fewer patients, say 2,000 to 2,500, but cannot afford to do so because a list of this size would yield too small a net income.

As a result, many doctors with maximum or near-maximum lists are obliged to perform hurried work, and the standards of diagnosis and treatment fall. This implies a danger to the public health. Many unnecessary referrals to hospital are made, which could be saved if the doctor had more time at his disposal.

This need (determined economically) to collect as many patients as possible leads to competition among doctors for patients ("head-hunting"). Prescribing and certification are often carried out more with an eye to satisfying the patient's wishes than to fulfilling his real medical needs. Professional isolation takes the place of co-operation among practitioners with sharing of experience and knowledge.

Although under the terms of the Danckwerts award each new entrant to the N.H.S. medical list attracts to the Central Pool an amount equal to the average doctor's remuneration, yet to his established colleagues in his immediate locality the newcomer is looked on askance as a potential competitor threatening to deprive them of part of their livelihood. Thus the established doctors will usually take what legitimate steps they can to try to keep out or squeeze out the newcomer.

All these circumstances tend to make it difficult for new doctors to enter practice as principals. A principal who wishes to share the burden of an excessive list of patients has a financial inducement to take a permanent assistant, in that he is allowed an additional list of up to 2,000 patients, the income from which more than pays the assistant's salary. On the other hand, there is a financial deterrent to the taking of a partner, since this involves the principal in an immediate and substantial drop in his income. Notional loadings are not enough to compensate for this.

The doctor who decides (often in desperation) to put up his plate encounters a number of obstacles to success. Since the coming into force of the N.H.S. practically the whole population is already registered with a doctor. Change of doctor was rendered more difficult for the patient by the restrictive regulations which came into operation in October, 1950. Except in certain special areas where new building or a shift of population is taking place, the building of a new practice is a slow and difficult business. It is true that the initial practice allowance is a help to the doctor starting a new practice in a designated area, but it decreases rapidly within a relatively short time, and only in the first year can it be considered commensurate with practice expenses. Its continuation in the second and third years depends, among other things, on the growth of the practice, a factor not within the doctor's control, and after three years it ceases altogether, a time when the practice cannot normally be expected to have reached its full size.

The fact that there is no natural law of averages tending to level out sizes of lists is demonstrated by the distribution of list sizes throughout the country. On 1st July, 1956, there were roughly equal numbers of doctors with lists in the ranges 0-1,500, 1,500-2,500, and 2,500-3,500 patients. (Reply by Mr. Vosper to Mr. Somerville Hastings, M.P., House of Commons, 12th April, 1957.) There were 540 lists below 500 patients, and 2,839 lists above the normal maximum of 3,500 patients for a practitioner not employing an assistant.

We have thus a situation where there is on the one hand a number of doctors with large lists of patients, who may be earning an income sufficient for their needs, but at the expense of perpetual overwork and rush, with the dangers that these entail; and on the other hand, side by side with these, a group of doctors who are under-employed and very badly off financially, but find it difficult or impossible to obtain sufficient patients to earn a living; while many more still are trying vainly to enter practice—some being actually unemployed.

Obviously this state of affairs reflects a badly organised health service. Ideally, the majority of practices should be in the middle range of list size. There should be no very large lists, and only a few, and only temporarily, very small lists, which it should be possible to bring up to the average level within a reasonably short time. In our view the capitation system as it stands provides a fair income for a fair amount of work only over a very limited range of list size.

In order to correct this maldistribution of patients, work, and incomes, it is essential that the maximum size of the N.H.S. list of patients be reduced to a level which will enable the doctor to devote all necessary time and care to his patients, and the distribution of general practitioner remuneration be so rearranged that the doctor is earning an adequate income, commensurate with his status in and his value to the community, when engaged in looking after a list of such a size.

In our view, the maximum number of patients on the N.H.S. list should be reduced by degrees (as financial and man-power resources permit) from 3,500 eventually to 2,000, and the additional list for an assistant from 2,000 eventually to zero. In sparsely populated rural areas, high morbidity areas, or where the doctor undertakes a substantial amount of work outside N.H.S. general practice,

the maximum list should be lower than this. Only then will the public receive the best possible service from their family doctors, and medical man-power be used to the best advantage.

II

PRESENT LEVELS OF REMUNERATION

Range of Incomes.—The average gross general practitioner income (before the recent interim increase of 5 per cent.) was said to be £3,337. This average is misleading, as the actual range of incomes is very great. From capitation fees alone it varies from zero (for a doctor starting a new practice without initial practice allowance) to £3,475 for a full list of 3,500 patients, or £5,175 for a list of 5,500 patients with an assistant (again not counting the recent increase). Since capitation fees account for only about two thirds of all general practitioner income, these figures are likely to be nearer £5,000 and £7,000 respectively, since the longer established doctor is likely to have the pick of any local authority, insurance referee or factory posts and the most private practice. The highest individual income known to us is £7,690, quoted as the income of a single-handed practitioner advertising for an assistant.

Bearing in mind that all general practitioners are, or should be, providing services of essentially a similar nature throughout the country, we believe that such a wide range of incomes cannot be justified on any logical considerations. We are of the opinion that the extent of the range from the lowest to the highest general practitioner incomes should be considerably narrower than at present.

Practice Expenses.—In calculating the central pool, allowance is made for approximately 38 per cent. of gross income to be spent on practice expenses. The application of this proportion to all practices is based on a fallacious assumption that all practices conform to the average in this respect.

In fact, the essential, genuine practice expenses do not vary very widely according to size of practice, and certainly not in direct proportion. It is not true that every patient on the list, whether the first or the 5,500th, involves the practitioner in the same amount of expense. A doctor with a small list spends a much higher proportion of his income on his practice than one with a large list, and a doctor starting a new practice may work at a loss for some years. On the other hand, in the higher ranges each additional patient adds relatively little to practice costs, and thus the patients at the higher end of the list produce a higher NET income than those at the lower end. The loading of the capitation fee is an attempt to compensate for this maldistribution, but its effect is limited, and the range of its application inappropriate.

The Spens Report.—The majority Spens Report on the remuneration of general practitioners is unsatisfactory because it recommends no minimum income, but only a lowest paid group of "under £700 p.a." (at 1939 prices). Hence the lowest gross income is zero, and the lowest net income less than zero because of practice expenses—a unique and quite unsatisfactory situation in a publicly organised health service.

In the application of the Spens Report the percentage distribution of different levels of income for various age groups recommended in the report is not used in deciding the incomes of general practitioners. In fact, even the numbers of general practitioners in each income group did not seem to be known to the Ministry of Health on 8th February, 1957. (Reply to Dr. Donald Johnson, M.P., by Mr. Vosper, House of Commons.) In practice the distribution of general practitioner income has been based on the abstract and meaningless concept of the "average practitioner". As a result, any resemblance between the Spens Report and the present distribution of general practitioner incomes is purely fortuitous.

Previous Adjustments in Remuneration.—These have all (including the last interim 5 per cent. increase) widened the already wide range, both for net remuneration and for practice expenses, since the increases of remuneration have always been based on the number of patients on the doctor's list.

III

PROPER CURRENT LEVELS OF REMUNERATION

We wish to emphasise that any flat rate increment which would again further widen the already wide range of incomes would in our opinion be quite unjustifiable.

The various defects of the present method of remuneration could in our opinion be put right if the following principles were applied:—

1. *Practice Expenses.*—There should be a basic payment to each practitioner in the N.H.S. as part of his remuneration, sufficient to cover basic practice expenses. We would suggest £750 p.a. as a reasonable figure. We realise that in such an arrangement reductions in the amount payable may have to be made in cases where a very small practice failed to grow at a reasonable rate, and that there might have to be safeguards against abuse. Also it might be necessary to make a reduced basic payment for doctors in partnership, since practice expenses of partners are relatively less per person than for single-handed practitioners.

2. *Increments for Age and Length of Service.*—There should be increments in respect of age and length of service in the N.H.S. This principle is well recognised in the case of other persons working in the public service, and of doctors in the Civil Service and working for local authorities. It would obviate the necessity for a practitioner continually to enlarge his list over the years in order to meet increasing personal and family commitments.

3. *Distribution.*—(a) Given the basic payment referred to under (1), the capitation fee should be at a standard rate for the first 2,000 patients on the list. Until such time as the maximum number of patients is reduced to 2,000, there should be a reduced rate of capitation fee for patients after the 2,000th. The combined income accruing from the basic payment plus the capitation fees for 2,000 patients should be fully adequate, independent of other sources of income, so that the doctor is able to devote his undivided time and attention to 2,000 patients.

(b) In the absence of the basic payment, the loaded range of the capitation fee should be shifted from the present one of 501-1,500 patients to 1-1,000. This measure would help to compensate for the higher expenses ratio of the smaller practice. The loading could be so adjusted as to reduce or eliminate the drop of income suffered by a principal who takes in a new partner (applying the present system of "notional loadings").

4. *Junior Partners.*—In order to prevent the exploitation of junior partners, in many ways similar to that which goes on in the case of assistants, it should be made compulsory that (a) a new partner's share on entry is not less than one half of the largest share in the partnership; (b) an incoming partner reaches parity or near parity with the other partner(s) in the practice in not more than five years from the date of his admission to the partnership.

5. *Health Centres.*—When more health centres are opened throughout the country, we believe that payment to health centre doctors should be on a non-competitive basis, e.g., by salary or sessions, and not by capitation. In this case the basic payment would not be necessary for health centre doctors, though increments for age and length of service would still apply.

IV

ARRANGEMENTS FOR KEEPING THE REMUNERATION UNDER REVIEW

In our opinion, Whitley Council A, for which there is provision, should be formed, and its Staff Side should include direct representation of practitioners with special problems, e.g., rural practitioners, small list practitioners, etc.

Memorandum of Evidence from the Executive Committee of the General Practice Reform Association to the Royal Commission on Doctors' and Dentists' Remuneration

REMUNERATION OF ASSISTANT GENERAL PRACTITIONERS PARTICIPATING IN THE NATIONAL HEALTH SERVICE

I

BACKGROUND TO THE REMUNERATION PROBLEM OF ASSISTANT GENERAL PRACTITIONERS

There are in England and Wales 1,546 assistant general practitioners employed by other doctors (principals) in general medical practice. The trainee general practitioners, numbering 386, are also employed privately by the principals, although the cost of their remuneration is met by public funds. (Figures quoted for 1st July, 1956, by Mr. Vosper in reply to Mr. Somerville Hastings, M.P., House of Commons, 3rd May, 1957.)

It is well known in the medical profession that both the assistants in general practice and those doctors in the hospital service in posts of limited tenure are in an unfavourable position economically, are mostly without prospects of advancement, and are likely at some time to experience unemployment or underemployment. (For example, see Annotation, *British Medical Journal*, 1st April, 1950; "Entry into Practice", *Medical World Newsletter*, 29th August, 1952; Editorial article, *Lancet*, 26th February, 1955; "Unemployment and Underemployment in the Medical Profession", Supplement to *British Medical Journal*, 5th November, 1955, and 1st September, 1956; and numerous letters published in the correspondence columns of the medical journals during the past eight years.) It is also well known in the profession that many of the younger doctors trained in this country have been forced to emigrate in search of a livelihood. The situation of this unestablished section of the profession is becoming known to the general public. (For example, see "Young Doctor's Dilemma", *Daily Telegraph*, 27th August, 1954; "Doctor on the Dole", *News Chronicle*, 10th September, 1954; Hansard, questions by Mr. Somerville Hastings, M.P., 25th April, 1955; Hansard, Adjournment debate on unemployment in the medical profession, 24th April, 1956; Series, "Hospitals, A Doctor Talks" by Dr. Louis Goldman, *Observer*, 12th May-2nd June, 1957; "Doctor on the Dole", Chapter I, by Michael Johnn.)

We have ourselves received during the past six years many hundreds of communications from assistant general practitioners and other unestablished doctors complaining of financial hardship, unfair conditions of employment, lack of prospects, false promises of partnership from principals, and unemployment.

The Permanent Assistant.—The vast majority of assistant general practitioners have neither prospects of promotion to a junior partnership nor any foreseeable likelihood of becoming established as a principal elsewhere by other means. Assistantships are therefore no longer a temporary status to enable a doctor to gain experience before becoming a principal: the permanent assistant, forced to accept the terms offered by the principal or to face unemployment, has appeared.

This situation has caused the principals to regard the assistant primarily as an employee for material gain and not as a professional colleague. Confirming this attitude, the General Medical Services Committee (G.M.S.C.) of the British Medical Association has gone on record as accepting the system of permanent assistantships: On the "major question of principle (of) whether exception can properly be taken to one doctor employing another in circumstances which make it possible for him to derive financial benefit from so doing" it "holds the view that there is nothing improper or unethical in a principal enjoying a monetary reward in respect of the indefinite employment of an assistant . . ." (Supplement to the *British Medical Journal*, 2nd April, 1955, p. 151, from paragraphs No. 8 and 12.)

Contract of Employment.—In some permanent assistantship posts a written contract (usually prepared to the model supplied by the British Medical Association)

is signed, and in others the terms of employment are stated verbally by the principal to the assistant. The decision as to whether or not a contract should be signed is made entirely by the principal. Some principals insist upon such a document, since the assistant thereby signs away his right to practise independently in a wide surrounding area for several years. The permanent assistant is generally no better off for having a written contract, as he can still be dismissed at any time on relatively short notice. For example, in an investigation by questionnaire carried out by us in 1955, out of a group of 97 assistants who replied to this question, 49 stated that they had written contracts, and of these 32 considered that their contract was of greater benefit to the employing principal than to themselves (the remainder thought it was of equal benefit to both parties).

Conditions of employment.—The conditions of employment and hours of work vary greatly. In many cases there is no doubt that the assistant is grossly over-worked and has little free time (sometimes in marked contrast to the employing principal). The prevailing conditions of employment may be exemplified by the answers we received to our questionnaire in 1955, in which we sent over 1,000 questionnaires to assistant practitioners, and of which, unfortunately, only 113 were completed and returned:—

Hours of active work per week (number of replies: 101).

Working over 44 hours per week: 68.

Of these, 18 worked over 60 hours per week.

Night Duty (additional to hours of active work) (number of replies: 107).

On duty for more than 7 nights per fortnight: 52.

In 2 instances the assistant was on duty 12 nights per fortnight.

Week-end Duty, from Saturday midday until Monday morning (number of replies: 96).

On duty more often than alternate week-ends: 40.

In 4 instances the assistant was on duty every week-end.

Weekly Half-day Off Duty (number of replies: 102).

The majority had one half-day (=afternoon and evening) off duty during the week.

However, in 4 instances the assistant did not have a half-day off, and in 15 others he had only part of a half-day (i.e., afternoon or evening).

Statutory Holidays (number of replies: 97).

In all except 8 instances the assistant was on duty on some or all of the statutory holidays. For this service only 20 assistants had another day off duty in lieu of the statutory holiday. Extra pay for working on a statutory holiday was given in only one case.

Annual Holiday (number of replies: 109)

In 2 instances holiday with pay was not given.

In 1 instance there was only one week's holiday per year with half pay.

In 1 instance there was only one week's holiday per year with full pay.

(In the majority of cases, the assistant had not less than two weeks' holiday per year with full pay.)

Miscellaneous

The assistant usually had to provide a car for his use in the practice (for which he received a car allowance). Frequently the assistant had extraneous duties, most often responsibility for manning the telephone for the receipt of messages. In four instances the assistant had regularly to clean the surgery premises, and in one case to light fires.

Unemployment.—Why do assistant practitioners accept unjust conditions of employment? The answer is because the alternative is a period of unemployment.

During the 12 months prior to the receipt of our questionnaire, 40 out of 100 assistants replying to the question on unemployment stated that they had experienced involuntary unemployment, the average duration being 8 weeks.

II

PRESENT LEVELS OF REMUNERATION (EXAMPLES)

107 assistants replied to the question on their remuneration in our questionnaire. In 18 instances the salary was less than £800 per annum. Of these, 6 received £750 p.a., for which their hours of active work per week were respectively 40, 40, 42, 60, 62 and 72; 3 received £700 p.a. for 42, 48, and 55 hours of active work per week respectively; and one received £600 p.a. for 60 hours per week. The salaries are all inclusive, there being no extra payments for night duty, etc. (except in the one instance for work on statutory holidays). Free accommodation was provided in some cases because of night duty.

Of 100 vacancies for whole-time assistants (excluding trainees) advertised in the British Medical Journal during the six-month period November, 1956 to April, 1957 inclusive, the analysis of gross salaries offered is as follows:—

£700 p.a.	...	...	...	...	...	...	3
£800 p.a.	...	...	...	...	...	...	2
£900 p.a.	...	...	...	...	...	...	9
£1,000 p.a.	...	...	...	...	...	...	49
£1,100 p.a.	...	...	...	...	...	...	23
£1,200 p.a.	...	...	...	...	...	...	13
£1,300 p.a.	...	...	...	...	...	...	1

III

PROPER CURRENT LEVEL OF REMUNERATION OF ASSISTANT GENERAL PRACTITIONERS

The permanent assistantship system has resulted in a principal-apprentice relationship being replaced by an ordinary employer-employee relationship. Hence we submit that the remuneration of assistant general practitioners should now be calculated on a basis of a minimum salary for a 5½ day day-time working week, with extra remuneration for the hours of duty in addition to this, whether spent in active work or being "on call", rights to all statutory holidays or other days in lieu, and to an annual holiday with pay.

Such a method would allow a standard minimum level of remuneration for all assistants for a 5½ day day-time working week, with higher minimum levels of remuneration proportional to the duration of extra work and on-duty time (calculated on a weekly or fortnightly basis).

We take this standpoint because there is no justification for the permanent assistantship system, which could and should be abolished. Until it is, and while assistants are in the same position as other privately employed individuals, we maintain that they should have the same rights.

With regard to the calculation of the standard minimum salary for 5½ working days per week, we should like to mention that the Spens Committee recommended that, at 1939 prices, a recently qualified doctor should receive a net salary of not less than £500 p.a. for his work as an assistant. Assuming this figure (converted to current value of money) to be appropriate for trainee general practitioners, it naturally follows that the standard minimum salary for an experienced assistant should be greater.

IV

ARRANGEMENTS TO KEEP THE REMUNERATION OF ASSISTANT PRACTITIONERS UNDER REVIEW

In reply to a question in our questionnaire, 69 assistants declared themselves in favour of the establishment of a Wages Council for assistant general practitioners, under the Wages Council Acts, 1945 and 1948. The 1956 Annual General Meeting

of the General Practice Reform Association also passed a resolution in favour of the establishment of such a Council.

We urge the Royal Commission to consider recommending the establishment of a Wages Council (or some similar machinery under the Ministry of Health) for assistant general practitioners participating in the National Health Service.

We plead this because assistants are at present defenceless and because we have failed in all our attempts to secure on their behalf either an effective direct negotiating machinery or any terms and conditions of service under the N.H.S.

Absence of Direct Negotiating Machinery.—Even if the main organisations of the employers (the British Medical Association and the General Medical Services Committee) were willing to enter into direct negotiations with representatives of the assistants, there would be no means of ensuring that the principals individually would carry out the terms of any agreement reached. This alone would seem to justify the setting up of some machinery under Departmental control.

The need for statutory protection is further reinforced by the failure of all the attempts to secure an effective yet independent organisation of assistant general practitioners.

The following is a brief account of the thwarted efforts to obtain such an organisation:—

1. *The Unestablished Practitioners Group (U.P.G.)* was formed in November, 1950, its name being changed to the *General Practice Reform Association (G.P.R.A.)* at the Annual General Meeting of 1954. Owing to practical organisational difficulties, we are unable to remain in contact with a majority of the assistants at any one time. Moreover, we are not concerned solely with assistant practitioners, but also with other unestablished doctors and with the problems of the health services generally.

2. On December 3rd, 1950, we applied to the Council of the B.M.A. for the formation of a *Special Group of the Association* for assistants and other unestablished general practitioners, such as had already been formed somewhat earlier for hospital registrars. Following this, we attended by invitation a meeting of the G.M.S.C. (Dec. 14th, 1950) and of the Organisation Committee of the B.M.A. (Jan. 2nd, 1951) for discussions on our application. The B.M.A. did not agree to form the Special Group we had requested.

3. The G.M.S.C. offered, however, as an alternative, to allow its *Assistants' and Young Practitioners Subcommittee (A.Y.P.S.)* to have elected, instead of co-opted representatives of assistants and unestablished principals sitting with the G.M.S.C. members on this subcommittee. To this proposal we stated in a letter to the Secretary of the G.M.S.C. (Feb. 5th, 1951) that we were of the opinion "that the proposed subcommittee method of organisation would be very suitable, provided that the elected representatives would constitute a national committee as well as being members of the proposed subcommittee". This condition was not accepted by the G.M.S.C. Consequently the A.Y.P.S. has always functioned only as a subcommittee of the G.M.S.C.—the employers' main executive organ—and not even as a relatively independent organisation for assistants and unestablished principals: the Chairman of the A.Y.P.S. has always been a G.M.S.C. member of the Subcommittee and never an assistant or unestablished principal; the Secretary has always been the Secretary of the G.M.S.C.; any resolution or proposal by the A.Y.P.S. can always be rejected by the G.M.S.C.; and the A.Y.P.S. cannot give its views by any route other than through the G.M.S.C.

4. The G.M.S.C. agreed that one assistant practitioner from the A.Y.P.S. should sit on the parent Committee and that the G.M.S.C. should request Local Medical Committees—representing mainly the N.H.S. principals at local level—to co-opt an assistant practitioner when possible. Here, again, the representatives of the assistants can only be regarded as participants in their employers' organisation.

5. Following our disappointments with the B.M.A., we attempted to have an organisation for assistant practitioners formed within the Medical Practitioners' Union (M.P.U.), and a resolution with this aim was passed by the Union's Annual

General Meeting of 1953. A constitution and provisional policy for a special *Section of the M.P.U. for Assistant and Trainee General Practitioners* were carefully drafted and were approved by both the Union and ourselves. The Inaugural Meeting was called by the General Secretary of the M.P.U. for Jan. 28th, 1955 by means of a circular letter. But the issuing of this circular was criticised at the January meeting of the G.M.S.C. (Supplement to British Medical Journal, 5th February, 1955), on which the M.P.U. has two delegates, one of whom is its General Secretary. A second circular letter from the General Secretary of the M.P.U., dated Jan. 26th, 1955, was consequently sent to assistants, informing them that the Inaugural Meeting had been postponed "in view of the misunderstanding" which had arisen; and to the best of our knowledge nothing has since been heard of the M.P.U. Section for Assistant and Trainee General Practitioners.

Absence of Terms and Conditions of Service under the N.H.S.—Efforts to secure any defined Ministerial terms and conditions of service for assistants have so far been unsuccessful.

1. On 23rd October, 1951, we had a *meeting with Officers of the Ministry of Health* to discuss the conditions of employment of assistant general practitioners participating in the general medical services of the N.H.S. The Officers' view was that, as assistant practitioners were employed privately by the principals, and were not in contract with the N.H.S. Executive Councils (and notwithstanding our argument that the assistant's employer's 8 per cent. Superannuation contribution was paid by the Ministry), the Ministry of Health could not introduce any regulations dealing with conditions of employment of the assistants. (It was at this meeting, however, that the possibility of a Wages Council was first suggested.)

2. We submitted *written and oral evidence to the Committee of the Central Health Services Council on General Practice within the National Health Service* in 1951, and further written evidence in 1953. In its report published in 1954, the Committee failed to make any positive recommendations on the conditions of employment of assistants on the grounds that it believed that "the doctor-assistant relationship is not more open to abuse than are other similar professional arrangements", and that sufficient safeguards were provided by "the making of proper agreements between the parties concerned . . . and the fact that both parties are at liberty to dissolve their agreement at relatively short notice". No account was taken of the development of the permanent assistantship system, its causes and implications.

3. After a protracted struggle in the A.Y.P.S., the maximum concession from the G.M.S.C. which ultimately emerged, and which was passed by the Annual Conference of Local Medical Committees in 1955, was that consent for the employment of an assistant by principals in the N.H.S. should be periodically reviewed, and where appropriate this consent withdrawn or the number of extra patients permitted to the principal reduced. It was "felt that that (recommendation) would ensure that there was no gross exploitation". (Supplement to the British Medical Journal, 28th March, 1955.) Even if this were to be so, it would be quite inadequate, as elimination of cases of gross exploitation is not acceptable in lieu of obligatory positive minimum standards of employment. It seems to us, moreover, that even the cases of gross exploitation will not be eliminated by the reviews, as these are to be undertaken, not by an impartial body such as the Executive Council themselves, but by the local executive organ of the employers: "It is the intention that in all material respects the Local Medical Committee should be the body which should look at each case and bring forward a recommendation to the Executive Council" (loc. cit.).

Thus the G.P.R.A. feels that there is only one fair and satisfactory solution: a Wages Council (or similar machinery under the Ministry of Health), and we hope that the facts which we have submitted will lead the Royal Commission to consider recommending such machinery for keeping the remuneration of assistant general practitioners under review.

Explanatory Note by the Royal Commission

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence, to all representative medical organisations:—

- (i) The quality and quantity of recruits (a) offering themselves and (b) accepted for training as medical students.
- (ii) The quantity and quality of newly qualified doctors.
- (iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.
- (iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).
- (v) The position and prospects of a newly qualified doctor.
- (vi) Any trend to excessive resort to certain branches of the profession at the cost of others.
- (vii) The relative advantages and disadvantages, financial and otherwise, of service as:—
 - (a) a principal in single-handed general practice,
 - (b) a partner in general practice,
 - (c) a whole-time consultant in the National Health Service,
 - (d) a part-time consultant with the maximum number of sessions,
 - (e) a part-time consultant with only a few sessions,
 - (f) a Senior Hospital Medical Officer,
 - (g) a doctor in any other sort of practice or employment.
- (viii) The difficulties encountered by member of the registrar grades.
- (ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.
- (x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.
- (xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.
- (xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service.
- (xiii) Any anomalies in the methods of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume.
- (xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.
- (xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.
- (xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.
- (xvii) Special considerations of which account ought to be taken in discussions of medical remuneration.
- (xviii) Specific proposals for medical remuneration.
- (xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.
- (xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.
- (xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

Memorandum of Evidence from the Executive Committee of the General Practice Reform Association to the Royal Commission on Doctors' and Dentists' Remuneration

FURTHER WRITTEN EVIDENCE

INTRODUCTORY

In the two documents which we have already submitted, we gave our views on the subjects generally of each of the three points in the stated terms of reference of the Royal Commission, for general practitioner principals and assistant general practitioners respectively, together with brief introductory sections in each document on the relevant background to the remuneration problems of these doctors serving in the N.H.S. This evidence was compiled prior to receiving from the Royal Commission its statement detailing a number of points on which information was sought.

In the evidence presented here, we have endeavoured to answer in further detail those among these points (13 in all) on which we believe we have information which may be of assistance to the Royal Commission. The items dealt with are presented in the order in which they occur on the list received from the Royal Commission, and are referred to by the same numbers as they bear on that list.

ITEM (v)

THE POSITION AND PROSPECTS OF A NEWLY QUALIFIED DOCTOR

We have already indicated in Section I of our earlier evidence on Assistants' remuneration that in our view the position and prospects of the newly qualified doctor are most unsatisfactory.

The newly qualified doctor generally has little difficulty in obtaining some sort of employment somewhere in the country, as many hospitals are chronically short of junior staff, though there is difficulty for most in obtaining posts which offer special advantages, e.g., posts approved for higher examinations, teaching hospital appointments, etc. Periods of unemployment between posts do, however, occur.

These early posts are notoriously ill paid. Apart from the low gross salary, a sizeable deduction is made for residence, which is a condition of employment anyhow, and no tax rebate is obtainable on this account. The young houseman finds himself paying tax on £125 which he does not get. If he has a wife and family he has to provide a second home out of the pittance which remains. The argument that the young doctor in his pre-registration year is little more than a student completing the final stages of his training and thus does not qualify for more than a very modest salary has no relation to reality. His position in the hospital—at any rate in the non-teaching hospitals—is in no way comparable to that of an apprentice. The pre-registration house officer carries a considerable degree of clinical responsibility, and often has to take important decisions, especially at times when his seniors are not in the hospital. In addition he has to provide an all-round-the-clock service, being unable to leave the hospital except during off-duty hours, which in most cases can hardly be considered generous.

One of the unfortunate results of the present-day organisation of the health services is that the doctor who wishes to obtain varied all-round experience before deciding which branch of medicine he wishes to follow often finds himself at a disadvantage in competition with others who have concentrated on their chosen path from the very beginning. The tripartite administrative arrangements keep the hospital and general practitioner services in separate watertight compartments, and allow little opportunity for free exchange of doctors between them. To spend several years in different specialities before applying for a senior post in one of them, or several years in hospital before entering general practice, is often to lessen ones chances of obtaining the desired appointment, witness the difficulty experienced by displaced registrars in getting into practice, and the virtual impossibility of becoming a consultant after having been in general practice. This is undesirable,

for it results in a profession consisting of doctors with little appreciation of one another's work and a lack of sympathy between them. It also results in having both consultants and G.P.'s not as fully educated (in the widest sense of the word, medically) as they might have been; this prevents the patient from getting the best possible service.

The doctor who wishes to enter general practice finds artificial barriers in his path; these will be fully considered under item (ix) of this evidence.

The unsatisfactory conditions of work and prospects of newly qualified doctors today may be illustrated by the following extracts:—

Extracts

"... the prospects of a doctor becoming a consultant between the ages of 35 and 40, or a principal or partner in general practice between 30 and 35, are still not as good as they should be." (From an editorial article, *Lancet*, 26th February, 1955.)

"Many of those who apply for admission to the medical schools, like those who embark on the career of general medicine today, must feel that there is now a very definite restriction of entry into the profession." (From "The Apprentice in Medicine", *British Medical Journal*, 16th April, 1955, p. 967.)

"It is clear that in Great Britain at the present time the chance of becoming a consultant in hospital practice or a principal or partner in general practice is too difficult and too uncertain." (From "Opportunities for Medical Practice at Home and Abroad", by Sir Stanley Davidson, *British Medical Journal*, 14th May, 1955, p. 1171.)

"A dilemma faces the young doctors of Britain today, for they are qualifying in a country which appears to many of them to be grossly over-doctored. That, at least, is the impression they get when they measure the chances of attaining consultant status or a principalship in general practice." (From "Young Doctor's Dilemma", *Daily Telegraph*, 27th August, 1954.)

"A few years ago it would have been unthinkable that doctors should draw unemployment benefit, but some of them are doing so today." (From an Annotation, *Lancet*, 9th March, 1957.)

Speaking about the future of 1,000 young doctors who would be released from the Services when National Service ends in 1960, Mr. H. E. Harding, Dean of Westminster Medical School, said that he could not find any responsible body had yet concerned itself about finding them jobs in civilian life; he shared the concern of these young men about their future. "They represent", he said, "an enormous potential of medical skill and the problem of their future employment can only be determined by national policy after careful enquiry. The National Health Service in its existing establishment, budgeting and planning has given no assurance that the problem is any less than I have postulated." (Report in *The Lancet*, 12th October, 1957, p. 751.)

Dr. Donald Johnson, M.P. (Conservative, Carlisle) asked if the Minister of Health was aware of the number of qualified doctors who were emigrating to appointments in the Commonwealth and the U.S.A. owing to not being able to find appointments in the National Health Service. (Parliamentary report, *British Medical Journal*, 3rd August, 1957, p. 304.)

ITEM (vii)

THE RELATIVE ADVANTAGES AND DISADVANTAGES, FINANCIAL AND OTHERWISE, OF SERVICE AS:—

(a) A Principal in Single-Handed General Practice

Advantages.—The single-handed principal is financially independent, as he does not have to share his income. He is not exploited by any other doctor. He can run his practice exactly as he wishes. His position is not affected by any other doctor, e.g., a partner who becomes ill or otherwise incompetent.

Disadvantages.—His practice tends to bear a higher expenses ratio than a partnership practice. He has to be available for his patients at all times, and cannot take any time completely off duty or leave the area of his practice, unless able to take part in a rota of local practitioners for mutual cover. (This practice is not prevalent everywhere, and is impossible in some rural communities as there is no other doctor near enough.) Any longer period of absence, whether on account of illness, holiday or refresher courses, necessitates the services of a locum tenens. The single-handed doctor tends to suffer a certain amount of anxiety, both as regards the need to be always available (e.g., he cannot afford to be ill) and always responsible, and also through not being able easily to obtain a further opinion and discussion about patients who present problems. This anxiety does not exist to the same extent in partnership practices. Because he is constantly at risk to all his patients, he cannot carry as high a load as the doctor in partnership. He lacks the stimulus of professional contact with his colleagues, tends to get into a rut in his methods of working, and can easily become complacent and unaware of advances in treatment or of his own shortcomings. More than any other doctor, he sees his neighbouring practitioners as competitors rather than colleagues.

(b) A Partner in General Practice

Advantages.—Practice expenses are shared, and therefore often lessened. In particular, the cost of practice premises and of some equipment can often be shared, as also the wages of ancillary staff (whom a single-handed doctor may not be able to afford to employ). The employment of holiday locums is often avoidable, the remaining partner(s) taking over the absent partner's work. Half-day and week-end off duty is easily arranged. A doctor in partnership is not professionally isolated. The efficiency of a partnership can be enhanced if different partners have special knowledge and experience of special branches of medicine.

Disadvantages.—Harmony within the partnership depends upon co-operation between the partners, and compatibility of their personalities as well as those of their wives; this is not always found, especially in the larger partnerships. If one member of a partnership does not pull his full weight, an undue proportion of the work is thrown on the others. Under present conditions, junior partners may be obliged, as a condition of the partnership, to accept terms and conditions to which they object, such as a disproportionate amount of evening and night work, an unduly small share of the profits, or compulsory purchase of a practice house at the price asked by the senior partner. Such opportunities for exploitation of junior partners will continue until the present difficulties of entry into practice are overcome. If a junior partner adds to the practice income by doing outside paid work, his partner(s) receive the major share of the additional money he brings in.

(c) A Whole-Time Consultant in the N.H.S.

Advantages.—The satisfaction of being able to devote all his time and energies to a single job.

Disadvantages.—No earnings are permissible outside the salary for the appointment, apart from payment for domiciliary visits. In respect of the latter the whole-time consultant is at a disadvantage because he receives no payment for the first eight visits in every quarter. Private practice is not permitted. No mileage allowance is given other than for domiciliary visits. Only very limited expenses can be claimed for income tax purposes.

(d) A Part-Time Consultant with a maximum number of Sessions

Advantages.—Private practice is permitted, and there is no limit to the income that can be earned. Earnings outside the N.H.S. can easily amount to much more than the difference between his salary and that of a whole-time consultant of equivalent standing. Subject to a maximum number per quarter, all domiciliary visits are paid for. Car, consulting room, and other expenses can be claimed against income tax.

Disadvantages.—The part-time consultant usually has sessions at a number of hospitals, so that he can devote only a proportion of his time to the patients under his care at each hospital. Because of outside commitments and of time lost in travelling,

the part-time consultant is liable not to give as good value for money as the whole-timer.

(e) **A Part-time Consultant with only a few Sessions**

As the circumstances of such consultants are subject to very wide variation, especially as regards the amount of private work done, no useful comment can be made on this group.

(f) **A Senior Hospital Medical Officer**

Disadvantages.—The doctors in this grade, which was established at the beginning of the N.H.S. as a temporary expedient, but which has since expanded considerably more than the consultant grade, are in an invidious position. They may carry clinical responsibilities as great, or nearly as great as those of consultants, but their remuneration is considerably less, and their prospects of promotion poor. They are, in fact, used as a cheap source of consultant labour, but are likely to remain in their grade for the remainder of their careers, since appointment to consultant rank is usually made from senior registrars and not from S.H.M.O.'s. They are unable to obtain merit awards, or to do private practice or domiciliary visits.

S.H.M.O.'s are inadequately represented on the negotiating committees that negotiate with the Ministry of Health.

(g) **A Doctor in any other sort of Practice or Employment**

The position of assistants in general practice is fully discussed in our earlier evidence on Assistants' remuneration, and under Items (ix), (xvi) and (xix) of this evidence.

ITEM (viii)

THE DIFFICULTIES ENCOUNTERED BY MEMBERS OF THE REGISTRAR GRADES

Bearing in mind the duties and responsibilities of the registrars and senior registrars, which, like those of the S.H.M.O.'s, are not infrequently of a consultant nature, they must be considered grossly underpaid by any reasonable standard. Those with wives and families have real difficulty in managing on the low salaries they receive.

It must be remembered that these men have reached their position only after several years of hard work in the more junior grades, and have often obtained higher clinical qualifications. Nevertheless, not only is their skill and experience not recognised in their financial reward, but their prospects of advancement are at present doubtful, to say the least. At each stage of promotion the difficulties experienced in obtaining a more senior post increase, since the vacancies become fewer and the competition more severe. Many of these well qualified doctors are thus obliged to spend years drifting from one appointment to another in the same grade. The period of tenure for each appointment being generally limited to 2 or 4 years for registrars and senior registrars respectively, it is not even possible for those doctors to keep a permanent domicile. Repeated moves are necessary, involving family and educational upheaval, and additional expense.

A considerable proportion of registrars are destined, under existing arrangements, never to reach consultant or even S.H.M.O. rank, since the number of such permanent vacancies is insufficient. A consultancy falls vacant once in a professional lifetime, but a registrarship is filled by a new doctor every two years. Inevitably many ex-registrars join the stream of doctors seeking entry into general practice, and here too they find themselves at a disadvantage in getting in, despite their excellent qualifications, because their experience is regarded as too specialised, and because they lack experience of general practice.

Another of the registrars' grievances is that, in selecting candidates for more senior appointments, undue preference is given to those who have held teaching hospital appointments. In the scramble for relatively few teaching hospital posts, many must necessarily be unsuccessful, and these at present have little chance of ever becoming consultants. This discrimination against non-teaching hospitals seems to us to be both unjust and unjustified, for many major non-teaching hospitals can provide at least equivalent clinical experience.

Finally, the registrars have no direct representation on any of the bodies which negotiate directly with the Ministry of Health. Their only channel is via the Central Consultants and Specialists Committee, which is composed mostly of teaching hospital consultants, who are without a direct interest in the registrars' problems.

Illustrative Extracts

"Running through the hospitals of Britain today, invisibly linking doctors from one end of the country to the other, are three closely woven strands of frustration, fear, and despondency. Highly skilled though these men and women often are, they nevertheless go about their daily tasks in the bitter and frustrating knowledge that the future holds little promise for them in their chosen field of work. Fear of unemployment—and worse, of being unemployable—haunts them." (From "Angry Young Doctor" by Louis Goldman (Hamish Hamilton 1957), a shortened version of which was published in the Observer, May-June 1957.)

"Appointments at hospital outpatients departments are unobtainable for weeks ahead in many areas, but meanwhile well trained senior registrars cannot get employment as consultants." (Horace Joules, M.D., F.R.C.P., M.A.P.W. Bulletin, April, 1956.) Please see also extracts under Item (v).

ITBM (ix)

THE DIFFICULTIES OF ENTERING GENERAL PRACTICE, WITH SPECIAL REFERENCE TO THE POSITION AND PROSPECTS, FINANCIAL AND OTHERWISE, OF ASSISTANTS

"If a small list man was unable to keep his list at a reasonable size, let him retire gracefully or go elsewhere." Thus one of the members of the B.M.A. Representative Body is reported as speaking against a motion at the Annual Representative Meeting, 1957, to use the interim award to general practitioners to load the capitation fees for the first 500 patients on the list (B.M.J. Supplement, 20th July, 1957). The motion, needless to say, was rejected.

The above quotation sums up very accurately the attitude of the leaders of the profession towards their unestablished colleagues, though it is not often so frankly expressed. In this section we shall try to show that the scales are heavily loaded against the young doctor who must fight his more senior professional brethren to obtain a living, and that the present system caters very adequately for the protection of the established doctor from competition, and not at all for the need for more doctors in the N.H.S. This is why the notorious overwork among many general practitioners exists side by side with great financial hardship and considerable unemployment among the unestablished.

Let us consider separately the three ways of entry into general practice.

I—Appointment to a vacancy.—About 150 vacancies occur each year in England and Wales. The number of applicants varies, but is often over 100. The average age of applicants is about 36. We believe these figures can be confirmed by executive councils.

What is less easily checked is the actual prospects offered by each vacancy. The doctor who is lucky enough to be appointed—we use the word "lucky" advisedly—is not thereby assured of a good living. Many doctors in prospect of retirement allow their practices to dwindle by ceasing to take new patients, or even advising the old ones to go elsewhere. In the case of death vacancies, the delay which occurs before a successor is appointed results in many patients registering with other doctors in the area; during the illness preceding the doctor's death a neighbouring practitioner may have already been looking after the practice, and many of the patients will register with him. Sometimes even the premises are not made available to the new doctor, who finds himself with the remnants of a practice and perhaps no premises, and who must virtually rebuild the practice. (See examples 1, 2.)

Sometimes practices are not advertised but dispersed, or handed to a "logical successor". Some of these dispersals known to us are inexplicable, there being no obvious reason for not appointing a successor.

The method of selection also gives rise to considerable disquiet. Although no one would deny that selection committees must find it very difficult to choose from a

plethora of equally qualified applicants, yet some cases known to us raise the suspicion of influence in the selection bodies. (See example 3.)

Although it is widely held that young doctors nowadays can step into ready-made practices, comparatively few in fact do so, and many of these find themselves little better off than if they had started on their own.

II—Putting up a plate.—This is the time-honoured method of starting a practice. In days gone by one could be fairly sure of achieving a good living eventually, but the position is very different now, for the following reasons:—

1. Nearly all patients are already registered with a doctor, so the new entrant can only expand his practice by enrolling his colleagues' patients, except where there is a large influx of new population.

2. Patients wishing to change their doctor are hindered by the restrictive regulation which requires 14 days' notice to be given to the Executive Council. (Most are unwilling to adopt the alternative procedure of asking their old doctor to consent to a change.)

3. A "squatter" is looked on as a competitor by local established doctors, and he often finds himself in competition with branch surgeries (see example 4), or excluded by acquisition of the only available premises by local doctors (see example 5).

4. Classification of areas—which determines whether permission to put up a plate is to be granted or not—is done by rule of thumb on a doctor-patient ratio basis. This can be unrealistic where, for example, an area contains several very large practices, but one or two small ones which reduce the average size of list in the area; there may be special reasons for the small lists, such as an elderly practitioner, or one with a large private practice, and the area may well be able to accept another doctor, but owing to the lower average list, it may be classified as intermediate or restricted. Again, an area classed as a whole as intermediate or restricted on the basis of the average size of N.H.S. list may contain within it districts where an additional doctor is needed, and which should thus be classified as designated. It is also not widely realised that reclassification is not decided by population size, but only by numbers of persons registered, i.e., registered with an established doctor. Where there is a large influx of population, this may lead to inappropriate classification: people often do not register with a doctor until they require his services, perhaps months after moving in, and such people are not counted until they actually register. This ensures that local doctors' lists are well filled before an area is reclassified as designated (or from restricted to intermediate).

5. Initial practice allowance (I.P.A.) (payable in designated areas only) is subject in the second and third years not only to certain minimum rates of growth of the list, but to a total professional income limit. I.P.A. is insufficient for the doctor to live on and meet his practice expenses after the first year, unless he has an independent private source of income.

6. I.P.A. is payable once only. So if a doctor has once received it and is unable to build up a list fast enough, perhaps through no fault of his own (e.g. illness), and has to give up, he cannot again claim the allowance, even if he is appointed to an advertised vacancy without a list.

III—By assistantship with a view to partnership.—This is the method recommended by the B.M.A. in their Handbook for Medical Practitioners as the best way of entry into practice. In conditions where the supply of potential entrants roughly equalled the demand for doctors, such a method might work reasonably well. There is no objection in principle to the idea of a doctor working for a short spell as a salaried assistant, during which time he and the principal can decide whether he should remain in the practice, and principal and assistant can get to know each other and decide whether their personalities are compatible. Unfortunately, under existing conditions, all the advantages of such an arrangement are with the principal, who benefits financially by employing an assistant at a low

salary for as long as possible, but stands to lose a proportion of his income if a fair partnership share is offered to the assistant:—

1. Owing to the large number of doctors seeking openings, there is no shortage of applicants. Even a vacancy for a permanent assistant may attract dozens of applications, and where a "view" is mentioned the number is greatly increased (see examples 6, 7). Thus if one candidate refuses unfair terms and conditions of employment, others can always be found who will accept.

2. The assistant is a profitable source of income to the principal, since he enables the additional list of up to 2,000 patients to be carried. In July, 1952, of 981 assistants employed by single-handed principals, no fewer than 720, or 73 per cent, were working in practices of over 3,600 patients. (Report of special sub-committee of the G.M.S.C. appointed in 1955 to study the problem of assistants.) The inducement is thus to employ an assistant without view if possible, or if with a view, to delay the implementation of the partnership for as long as possible; or to make a pretext for refusing the promised partnership at the expiry of the probationary period, either directly or by imposing unacceptable conditions of service (see examples 8, 9, 10, 11, 12, and 13).

3. Whenever a doctor taking up an assistantship—whether with or without view—signs an assistantship agreement, the latter almost always contains a restrictive covenant preventing the assistant from practising independently for a considerable period in an area containing and surrounding the practice. Thus, if the "view" fails to materialise for any reason, the principal is automatically protected from competition by his ex-assistant, while the latter is unable to make use of any goodwill he has acquired in the area while practising there, even if he has been dismissed without good cause.

4. If a share is offered, the principal is unable to obtain any financial recompense for parting with a proportion of his income to a junior partner. The only present financial inducement to taking a partner is the "notional loading" arrangement, and in its present form this does not do enough to prevent the principal from losing income. As a result, all sorts of subterfuges are resorted to which amount to no less than sale of goodwill, though performed in a manner designed to escape penalties under the N.H.S. Acts. The obvious example is the employment of an assistant for long periods before admitting him to partnership. Others are:—

Offering an unduly small share of the partnership profits (see examples 11 and 14).

Giving the junior partner an undue proportion of the work, especially night and week-end work.

Forced purchase of the principal's house (see examples 15 and 16).

Compulsory purchase of share of capital equipment at an exaggerated price.

Employment of partner's wife as secretary-receptionist, or charlady, without payment (see example 12).

The foregoing considerations have been concerned with the difficulties of entry into practice. On the subject of the employment of permanent assistants in the N.H.S., our views have been set out in our earlier memorandum of evidence on assistants' remuneration. We would merely like to reiterate here our view that to pay one doctor for the work done by another is immoral, a misuse of public funds, and a practice deleterious to the best interests of the profession. We strongly oppose the opinion expressed by the special Subcommittee of the G.M.S.C. appointed in 1955 to study the problem of assistants that "there is nothing improper or unethical in a principal enjoying a monetary reward in respect of the indefinite employment of an assistant, provided that the salary and allowances paid are commensurate with the responsibility and work undertaken and that the assistant has had no reason to believe that the appointment offered would lead to a partnership". If a doctor is considered fit to do a large share of the practice work, he is entitled to the benefits and rewards of principalship.

Examples

The following examples, which are alluded to in the foregoing text, are of personal experiences of our members and other doctors who have written to us. Fuller details of any of the examples will be supplied if required. We have on our files many other similar examples, particulars of which can also be supplied.

Appointment to advertised vacancy. *Example (1).*—A vacancy advertised in the spring of 1957. At interview candidates were told that the premises had been sold and would not be available. The practice (900 list at time of advertising) was being looked after by a neighbouring doctor from his own premises.

Example (2).—(From a letter to the G.P.R.A.) "I applied for 62 Executive Council vacancies . . . at one of these I was the successful candidate . . . The vacancy was a death vacancy with a list of 880 patients. It attracted over 40 applicants. Over 200 of the patients had removed themselves from the list before I was appointed. During the ten weeks between the principal's death and my taking up the practice, it was looked after by one of the local practitioners."

Example (3).—End of 1956, a large practice of 4,000 patients, a death vacancy. Although many excellent applications from unestablished doctors were undoubtedly received, among them a double application from a pair of doctors prepared to work in equal partnership, one living less than two miles from the practice, the practice was given to a doctor who was already a junior partner in the same E.C. area. (Incidentally, he would have been bound to employ a permanent assistant from the start to comply with the regulations for maximum lists.)

Putting up plate (or appointment to executive council vacancy without a list). *Example (4).*—Doctor appointed to an advertised vacancy without a list (Middlesex) writes: "Imagine my dismay when, after eight weeks' nerve-racking search I eventually found a small house in the area to rent, only to find that the big firms from the nearby two towns had set up lock-up surgeries, so that now where there previously had not been a doctor, there are ten practitioners' plates displayed in places of vantage. Their representatives have advised me not to set up against them since the odds against me were too great".

Example (5).—Intermediate area, large new housing estate, 700 houses already built and another 800 under construction. Nearest doctor about a mile away (with large list).

Early 1957: Approach made to Executive Council asking to have the estate declared a designated area: this was refused.

Spring, 1957: Approach to local housing committee for premises: informed that no premises were available, but that the matter was under discussion and would be decided later.

Summer, 1957: Further approach to housing committee, to be informed that premises had been made available to local doctors for part-time surgeries and therefore allocation of premises to a new doctor could not now be considered.

Autumn, 1957: Permission to start a practice at last granted by Executive Council. Further application made to housing committee, to be told again that there is no chance whatever of obtaining premises. Meanwhile other doctors, living at considerable distances from the estate, are opening their part-time branch surgeries.

Assistantship with view—difficulty of finding a vacancy. *Example (6).*—Doctor aged 30, with hospital and trainee general practitioner experience, writes: "In twelve months I wrote to 64 advertisers (in journals). I had no reply from 30, 'regret vacancy filled' from 34. No interviews. I applied for 13 vacancies from the (B.M.A.) Advisory Bureau, and received 13 replies regretting vacancy filled".

Example (7).—Doctor aged 29, qualified 5 years, holding D.R.C.O.G., hospital, services and general practice (including trainee) experience, writes, after failure to obtain a post after many applications: "I intend continuing my search for a suitable vacancy in medical practice for the next three months. If still unsuccessful at the end of that time, I shall attempt to find a position outside the profession."

Assistantship with view—failure to implement view Example (8).—Doctor aged 33, qualified 8 years, including 3 years' general practice experience, writes: "Here is a developing area with an urgent need of one or more doctors. To my knowledge, this firm have had at least two former assistants who had come with 'a view', but they were not found 'suitable'. The same has happened to me; now they have employed a locum for 3 or 4 days to be followed by yet another 'assistant with view'."

Example (9).—Another doctor writes of his experiences in an assistantship with view: "My employer had had several previous assistants with a view (number uncertain) . . . It was very difficult to work with him, due to inconsistency. I never felt confident of his support. I did four surgeries a day except on Sundays, and two surgeries on the weekly half-day . . . In the agreement I was entitled to some holiday after 6 months. I asked for a few days after 7 months because my wife (who was pregnant and helped in the branch surgery) and I were very tired; this was refused. At this time I protested about the work and no effort was made to discuss it with me, so things went on as before. As a result of my protest he immediately decided not to consider a partnership with me, and started to look for another assistant while pretending to consider partnership with me."

Example (10).—From another assistant with view: "The fact that the view was not to be implemented was made known in the following circumstances: I had to ask the principal 'what about it' when the prescribed probationary period in the agreement (up to a year) was exceeded. I was then told that the practice income had fallen, due to facts which were known some six months earlier. I was kept waiting for news that I should not be taken on after all, and this delayed my seeking elsewhere. The principal has now declared that it has been his intention to drop his appointments, and to allow the reducing practice to dwindle as slowly as possible to manageable single-handed proportions, taking a temporary assistant in the busy months of the year."

Example (11).—From another disappointed doctor: "In 1949 I obtained employment as an assistant with a view to partnership. At the end of two years I was indeed offered a partnership. The terms of this partnership, however, were that the junior partner should receive £1,000 out of the first £3,000 profit, and one quarter of any profit in excess of that sum. Moreover the senior partner retained the right to dismiss the junior partner after due notice . . . The proposed agreement was submitted to the Medical Practices Committee for their observations. The terms of this agreement did not approach the terms recommended by the Medical Practices Committee, and, acting on my solicitor's advice, I sought other employment."

Example (12).—Another doctor describes the terms of partnership offered to him as follows: "That I should have a 25 per cent. share, which would in effect give me a net income (after deduction of expenses) of less than I was already having as an assistant. That I should be on duty every Sunday without exception. That my wife should be responsible for answering all telephone calls, failing which I should pay someone, out of my own share, to deal with these." He goes on to say that, after taking legal advice, he suggested a larger share, some readjustment of unfair off duty, and a little freedom for his wife. Soon afterwards the assistant was told that the principal could not see his way to offering him a partnership at all. The principal added, however, that he had no fault to find with the assistant's professional work.

Example (13).—From a letter to the G.P.R.A. dated August, 1957: "Came here in 1953 and was told after a year that they would like me to stay as a partner when the practice could afford it. Since then about 800 patients have been added. Last week I was told that they could not consider taking on a new man—postponed indefinitely."

Example (14).—From a letter to the G.P.R.A.: "My next job was at first without the promise of a partnership, but when, after the Danckwerts award, it became profitable for principals to make their assistants into partners, my then employer, for whom I had already been working for two years, offered me a partnership. In this case the junior partner was to receive one third share of the profits of the partnership, subject to a further two years' probationary period, but with no arrangement

for an increase in the share. I felt obliged to decline this offer of a partnership, and was summarily dismissed. For these reasons, and others, I gave up general practice."

*Assistantship with view—compulsory purchase of premises. Example (15).—*Vacancy advertised through B.M.A. Advisory Bureau: Partnership with view to succession offered, a condition of partnership being the purchase of the principal's house, containing surgery, for £8,000. (If this were a fair price for the house, it is too large for a young doctor, and would take many years to pay for.)

*Example (16).—*From a letter to the G.P.R.A.: "Following three years with a view which did not materialise I took an assistantship at £500 p.a. with a definite view. The principal gave me one month's notice because I refused to buy his surgery before I became a partner . . . My successor became a partner the day after I left."

Extracts

The following extracts illustrate some of the problems of entry into practice:—

" . . . Many letters have appeared in this Journal testifying to the discomfort and resentment felt by assistants who have been unfortunate in their choice of principal." (From an Annotation in the British Medical Journal, 1st April, 1950.)

"The proportion of the profession engaged in general practice is considerably lower than in 1911, being probably not much over 25 per cent. The number of those looking for opportunities to get into general practice is large, and many of these have spent long and sometimes depressing periods as assistants and trainee assistants." (Sir John Conybeare, K.B.E., M.C., M.A., D.M.Oxon., F.R.C.P., The Lancet, 18th May, 1957, p. 1032-35.)

"Most informed people agree that entry into practice (in Britain) as at present too difficult, and a good deal of harm has resulted from this state of affairs." (From "General Practice in America and Great Britain" by C. M. Fleming, M.A., M.D., F.R.C.P.Ed., British Medical Journal, 19th June, 1954.)

" . . . to attain the status of a principal is at present so difficult that an assistant may feel bound to accept terms of partnership which he does not regard as satisfactory . . ." (From Report of the Medical Practices Advisory Bureau for 1954, Supplement to the British Medical Journal, 26th March, 1955.)

"So the figure of 35 (doctors registered as unemployed) represents a much larger figure of doctors who are not attending the employment exchanges for obvious professional reasons, but are hanging about, either unemployed or under-employed, hoping for something to turn up. They are perhaps doing odd jobs for a day or two . . . It represents, too, a still larger number of doctors working as assistants in jobs without prospects." (Dr. Donald Johnson, M.P., in the Adjournment Debate on 24th April, 1956, reported in Hansard, Vol. 551, No. 139.)

"Of the 1,075 (doctors) circularised, 82 (approximately 8 per cent.) were actually unemployed—that is, undertaking no work of a professional nature even as a locum at the time of completing the form." (From "Unemployment and Under-employment in the Medical Profession" by L. S. Potter, M.B., Ch.B., Supplement to the British Medical Journal, 5th November, 1955.)

A second survey carried out on similar lines to the above in April, 1956, and reported in another article by Dr. Potter (Supplement to the British Medical Journal, 15th September, 1956) showed that out of 947 doctors circularised, 87 (9 per cent.) were unemployed at the time of completing the form sent to them.

Please see also the extracts under Item (v).

ITEM (xi)

EXPENSES IN GENERAL PRACTICE, HOW FAR THEY VARY ABOVE AND BELOW THE AVERAGE, AND HOW FAR PAYMENTS, E.G., TOWARDS CAPITAL, HAVE TO BE MADE WHICH ARE NOT ALLOWABLE FOR INCOME TAX PURPOSES

We have already indicated in our earlier evidence on N.H.S. Principals why, in our view, the method of payment of practice expenses by the N.H.S. is unsatisfactory. Expenses are reckoned as a fixed percentage (adjusted periodically to

allow for fluctuations in prices) of gross practice income, and this percentage is applied to all practices as part of the capitation fee. The method therefore suffers from the defect common to all payments which are based solely on the number of patients on the doctors list, namely, that those doctors with most patients receive too much money, and those with fewest too little, in relation to actual work and essential commitments.

It is necessary here to distinguish between those practice expenses which are really essential and those which are claimed for income tax purposes. The latter do in fact tend to rise with gross income, because that is encouraged by the income tax laws of this country: (a) *Larger expenses* are incurred—classically, a larger car—because "the State pays half", not because a better service ensues. (b) *Additional expenses* are incurred, e.g., a gardener or better replacement of furniture, or even a house apart from the practice (also "chargeable"), because these items are all to some extent tax savings, not because they provide a better service.

The really necessary expenses can be divided into those which are basic and unavoidable in every practice, since every doctor providing general medical services is bound to provide his own premises and equipment (or pay an equivalent rent for the use of rooms in a health centre), and those which vary according to the size of the practice.

The former include such items as the provision of surgery and waiting room accommodation; the rental of a telephone; the upkeep of a car; heating, lighting and cleaning of surgery; holiday and sickness relief, at any rate where the doctor is single-handed; and the maintenance of a supply of drugs and dressings for emergency use. All these items together constitute a major proportion of the expenses of most practices. They are basic and independent of the number of patients on the doctor's list. We therefore believe such basic expenses should not be derived from the capitation fee, but should be met in part by the N.H.S. by a standard basic payment (see Item (xviii) of this evidence).

The kind of expenses which increase in proportion with the size of the practice are, for example, petrol, numbers of telephone calls, stationery and postages. The larger practices can often afford the services of a dispenser or secretary-receptionist. Whether such ancillary help can be employed depends on the circumstances of the individual practitioner. Large partnerships can better afford to share expenses such as these than can single-handed doctors.

The services of an assistant frequently figure in the expenses accounts of doctors. Although in statistics of practice expenses, with which the Royal Commission is doubtless familiar, the salary of an assistant will often be included with other practice expenses, we do not believe that this item ought to be considered in the same category. For reasons which we have explained elsewhere in this evidence (see Items (ix) and (xii)), an assistant is often a source of profit to the principal, and thus the very antithesis of an expense.

In general, under the capitation method of payment, the more that a doctor spends on the provision of premises and equipment, the worse off he is financially, and it is therefore in his financial interest to maintain the minimum standard which will satisfy his N.H.S. obligations, which in practice means his own local medical committee.

We have no figures available as to how practice expenses vary above and below the average for the country as a whole. But we have got some statistics from our own members which confirm beyond doubt that for a small practice the expenses are well above the national average (which is said to be about 38 per cent. of gross income), and that in some cases it may exceed 100 per cent. A few examples may be cited here.

Examples

(1) Mining village practice, Scotland. Estimated average list for the year: 156. Total practice income, N.H.S. and non-N.H.S. sources (including £600 Initial Practice Allowance): £775.

Practice expenses: £611 (79 per cent.).

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(2) Country town, Home Counties, practice started by putting up plate: Estimated average list for year: 113. Total practice income from all sources: £162.

Total expenses: £362 (223 per cent.). (About £1,050 was earned from part-time hospital employment.)

(3) Industrial city, northern England. Practice list 1,054. Total income (including £100 special supplementary allowance): £1,524.

Expenses: £851 (56 per cent.).

(4) Industrial practice, south-east London. List 560. Total income, including £200 initial practice allowance and £270 from non-N.H.S. sources: £920.

Expenses: £460 (50 per cent.).

(5) West London practice. List 420. Executive Council income: £380.

Expenses: £537 (140 per cent.). (£770 was earned in part-time employment from locums.)

(6) Successor to advertised vacancy, east England. List about 680 when appointment taken up. First year's income was £934 from Executive Council sources, plus £168 from outside sources (including medical boards). Total: £1,102.

Expenses: £841 (76 per cent.).

All these examples are for single-handed principals. All are recent, being returns for the last full year of practice working. The expenses quoted are those allowed for income tax purposes. We have further examples available.

Capital expenses not allowable against income.—These may include such items as new buildings, improvements, additional capital equipment or furniture, and fees for examinations for higher degrees. We regret that we have no statistics available as to the incidence of these expenses.

ITEM (xiii)

ANY ANOMALIES IN THE METHODS OF PAYMENT OF ANY BRANCH OF THE PROFESSION,
E.G., MALDISTRIBUTION AS OPPOSED TO A WRONG TOTAL VOLUME

I. General Practitioner Principals

Under the present arrangements of capitation fee remuneration for general medical services, there are two important groups of anomalies: (A) the opportunity for a higher than usual rate of payment for the assisted principal with a large list, and (B) the inevitable underpayment of doctors with small lists.

(A): A practitioner with 5,000 patients on his list, for example, receives £4,950 from capitation fees and loadings (including the 5 per cent. interim increase). Assuming that he pays his assistant £1,000 p.a. (incidentally, allowable as an expense for income tax purposes), and does as much as approximately half the work (usually the principal does less than half the work when he employs an assistant), he is earning £3,950 p.a. for the work required for 2,500 patients. For the equivalent amount of work the single-handed practitioner earns £2,790 10s. 0d. In our opinion, this anomaly of remuneration—possible because of the association of the large extra list for the employment of an assistant with the capitation fee method of remuneration—represents not only a system of exploitation of one doctor by another and of profiteering at the State's expense, but also of unequal rates of remuneration for the assisted principal with an extra list as compared with the single-handed practitioner.

(B): Side by side with this relative overpayment by the N.H.S. of some practitioners with extra lists, there is underpayment by the N.H.S. for work carried out by doctors with small lists. This occurs because, in the absence of a basic payment, doctors with small lists generally do not receive capitation fees for sufficient patients not requiring attention to make up for those who do. This is particularly true of doctors starting new practices. The building of a practice depends on obtaining a sufficient number of new registrations. It is unusual for patients to register with a new doctor without wanting some treatment at the time of their first attendance. Thus the small-list doctor, and especially the "squatter",

has to work for each capitation fee he earns to a much greater extent than the established doctor with an average or large list.

*Example:—*For 51 visits and 31 surgery consultations during the first full year of a newly-started and slowly-growing practice (October, 1956 to September, 1957), the gross remuneration by the N.H.S. was £6 6s. 3d., an average of just over 1s. 6d. for each visit or attendance. This attention was required by 17 patients for the following 25 clinical conditions (the remaining patients not requiring any attention):—

A.H.B. (M. 46)	...	...	Routine examination and varicose veins
			Neurocirculatory asthenia
P.D.B. (F. 38)	...	...	Septic hand
			Rheumatic heart disease complicated by episodes of
			bronchitis, congestive heart failure and post-
			cardiotomy syndrome
B.G.B. (M. 23)	...	...	Epidemic influenza
K.A.B. (F. 19)	...	...	Furunculosis
			Septic finger
			Cystitis
E.P.C. (F. 30)	...	...	Pregnancy with threatened abortion
J.K.C. (M. 23)	...	...	Acute pharyngitis
D.E. (M. 21)	...	...	Ingrowing toenail
			Erythema solare
D.E. (M. 13 months)	...	...	Digestive disturbance
			Cervical adenitis
E.E. (F. 23)	...	...	Upper respiratory infection
H.F. (F. 59)	...	...	Chronic seborrhoeic dermatitis
P.F. (M. 59)	...	...	Routine examination
			Lumbago
H.J. (M. 21)	...	...	Ligamentous injury of knee
G.M. (M. 21)	...	...	N.H.S. sight testing form
E.G.N. (M. 44)	...	...	Haemangioma
			Anxiety symptoms
L.R. (M. 54)	...	...	Angular conjunctivitis
R.G.T. (M. 5)	...	...	Scarlet fever followed by measles, with protracted con-
			valescence
L.W. (F. 6 months)	...	...	Roseola infantum

It will doubtless be appreciated that generally for each case a history has to be taken; an examination carried out; a diagnosis made; treatment given, prescribed or arranged; and where required progress observed. As the above example shows, so far as small-list practitioners are concerned, underpayment occurs for N.H.S. work carried out. This practice was started in a so-called "intermediate area", but this fact in no way absolves the N.H.S. from the obligation of giving a fair rate of pay for work done.

Other Anomalies:—(1) The anomalies resulting from the estimation of practice expenses as a simple percentage of total capitation fee remuneration are considered under Item (xi).

(2) *The trainee general practitioner scheme* gives a very considerable advantage to those principals who are accepted as trainers. Even where the trainer carries out fully his obligations to instruct his trainee (and we have received a number of complaints from trainees that they have received no proper training, and have been given the bulk of the practice work to do), there can be no doubt that, after the first few weeks when the novice is initiated into the way of running a general practice, he becomes a useful source of additional labour in the practice. Before long he is doing surgeries and visits on his own, and thus saving the principal work. The cost of his salary (plus car allowance and training grant of £150) is met entirely from public funds. Though no additional list is allowed to the trainer principal in respect of a trainee, the services of what amounts to an assistant free of charge must be of potential financial value to the principal and his partners,

if any, by allowing more time for, for example, private work, outside appointments, etc. There is no limit to the number of trainees that one principal may employ in succession, and we believe that the scheme is sufficiently attractive financially to deter some doctors allowed trainees from taking partners.

(3) *Rural Practice*.—The rural practitioner has to work under conditions of considerably greater difficulty than the urban practitioner. His practice is scattered, and may cover a wide area. Many patients have to be visited for conditions for which, in a town, they could come to the surgery. Because of the greater distance from hospital Casualty and Outpatients departments, country doctors provide a greater range of services than town doctors who have a hospital close at hand. The country doctor thus spends more time per service, on the average, than the urban doctor, and thus needs to take on a smaller number of patients. The size of his list is also often limited by the smaller population of the area in which he works. His practice expenses, especially as regards car and telephone, are higher than those of the urban doctor. He may have to have branch surgeries for outlying areas. He can seldom benefit, if single-handed, from any rota system, and for holidays must pay the full expenses of a locum.

We believe that the mileage scheme in its present form does not compensate sufficiently for these disadvantages. For example, patients living within two miles of a rural practitioner carry no mileage allowance at all, whereas if the same patients are on the list of a doctor in the nearest town, the latter is paid mileage for the distance in excess of two miles. Although admittedly the town doctor's mileage is paid at a lower rate per unit, nevertheless this is compensated for by the greater number of mileage units he receives for a country patient, and the fact that most or all of his country patients carry mileage payments. By contrast, if a patient living in a "non-mileage area" (i.e., urban population of more than 10,000) is on the list of a rural doctor, the latter is allowed no mileage in respect of him, no matter what the distance. This arrangement appears to us to discriminate unfairly against the country doctor, and to discourage doctors from living in the country as opposed to treating rural patients from town surgeries, i.e., it encourages country practice rather than country practitioners. It also tends to interfere to some extent with the choice between doctor and patient, because a doctor may be reluctant to accept a patient living at a distance from him for whom he receives no mileage allowance.

4. *Dispensing*.—Dispensing doctors are required to collect and remit to the Executive Council the shilling levy on each item which they dispense for their patients. This money must be remitted whether or not it is actually collected from the patient (though executive councils may exercise discretion), and it is in some cases very difficult to collect it. The doctor thus stands actually to lose money through the prescription charge. The risk of losing money is greater in the case of doctors paid on the Drug Tariff than for those paid by dispensing capitation fee, because the former render a prescription for every item for which they claim payment, and therefore must produce a shilling for each such item. Although chemists are paid a small allowance for possible loss of uncollected shillings, doctors are paid nothing for this, despite the fact that it is much more difficult for a dispensing doctor in many instances to insist on the immediate payment of a shilling when drugs and dressings are dispensed at home than it is for a chemist, who is in a stronger and more impartial position to insist on the payment of the levy.

II. Assistant General Practitioners

As assistants have no protection, either by union or by regulation, the very method for deciding their remuneration—i.e., unilaterally by the principals—is an anomaly for this day and age. This anomaly is all the more startling by virtue of the fact that assistants work under N.H.S. arrangements; and it is made all the more inexcusable by the medical under-establishment of our health services (by modern standards, in comparison with, for example, the U.S.A. and the U.S.S.R.). In some instances the anomaly in the remuneration of assistants can only be described as exploitation (see Examples quoted under Item (ix) of this evidence).

III. Hospital Medical Staff

The work carried out by S.H.M.O.'s, senior registrars, and sometimes even by registrars is often of the same type as that done by consultants. The discrepancies in their remuneration are not justified in many instances.

Part-time consultants are liable not to give full value for money, because of outside commitments and time lost in travelling. We believe that 9 sessions per week may be too many for a part-time consultant to manage adequately, especially in view of heavy private practice commitments in some cases. (The consultant who arrives late and finishes early, leaving much of his work to a registrar or houseman, is a familiar figure with junior hospital staff.)

Nevertheless, some part-time consultants are allowed by Regional Hospital Boards to take on more than the permitted maximum of 9 sessions per week, even though they cannot be paid for more than 9. Such an arrangement may suit both the Hospital Boards (because it is economical) and the consultants (because appointments in a greater number of hospitals bring in a greater volume of private work). In our view, however, it constitutes a serious anomaly and is a thoroughly bad arrangement because (a) clearly, a part-time consultant cannot give his full attention to more than 9 sessions a week—perhaps even more sessions than the week contains half-days! (b) Other potential consultants are being kept out of appointment to sessions which they should properly be doing, and the entry into consultant practice is thereby artificially restricted.

Part-time consultants are paid for 50 domiciliary visits in every quarter. Whole-time consultants have to do 58 visits per quarter in order to get paid for 50.

Whole-time consultants receive no mileage allowance other than for domiciliary visits. They should surely be allowed at least to claim mileage in respect of extra journeys to hospital necessitated by medical emergencies.

Junior hospital medical staff are underpaid in relation to their responsibilities and hours of duty. In the case of the doctors who have, in addition to their day work, to live in hospital for night calls, the deductions made for board and lodging are anomalous: thus, for instance, a clinical registrar, compared with, say, a pathologist of registrar grade, may not only have to do additional night work, but has also to pay for this privilege! In the case of house officers, residence in hospital is generally a necessary condition of employment, yet no income tax allowances are given in respect of the cost of their living in hospital. Before the N.H.S., residential emoluments were provided free and were untaxed.

Junior hospital medical staff are required by their conditions of service to care for private patients in the pay beds of N.H.S. hospitals during the absence from hospital of the consultant in charge, but they receive no additional remuneration on this account.

ITEM (xiv)

COMMENTS ON THE PRESENT SYSTEM OF CALCULATING AND DISTRIBUTING GENERAL PRACTITIONERS' REMUNERATION THROUGH A CENTRAL POOL

We consider the system of a central pool to be unsatisfactory for the following reasons:—

1. Every new entrant as a principal on the list of an Executive Council enlarges the pool by over £3,000; and since, generally, for many years the new entrant's share from the pool is smaller than the amount by which the pool is enlarged for him, he subsidises the established practitioners—with the biggest share of the extra money he attracts into the pool going to the doctors with the largest lists.

2. The method causes inaccurate individual remuneration. Either the capitation fee must vary in different areas (as was the case before the Working Party Report) or the pool must show a surplus or a deficit. At present a uniform capitation fee is paid, leaving a margin for a surplus, which is distributed in proportion to gross earnings, once more giving a financial advantage to big-list practitioners.

The method of paying a final settlement one to two years late is unfair to the new entrant. Not only is the money withheld at a time when he badly needs it, but when he does receive it he has to pay income tax at a higher rate than he would if the money had been received at the correct time (assuming, as is probably true in most cases, that his total gross income has risen in the meantime, and that he has consequently become liable to tax at a higher rate than in his first year). This objection does not apply to established doctors whose income is fairly constant from year to year.

3. Certain first charges are made on the central pool before it is distributed as capitation fees (e.g., mileage, initial practice allowance, temporary resident fees, fees for emergency treatments and anaesthetics). These fees are paid for special services rendered, and ought therefore to be entirely independent of the funds which are required for the ordinary general medical services to patients.

4. The central pool method of remuneration inevitably gives rise to antagonisms within the profession regarding its distribution; and these are naturally resolved to the advantage of the more powerful interests. It also results in the Departments concerned losing their full responsibilities regarding unsatisfactory distribution and use of the public money spent on the general medical services—e.g., anomalies of remuneration (see Item (xiii))—and maintaining maldistribution of patients among the practices by means of discouraging change of doctor.

We believe that a method of individual payment can and should be devised which is not dependent upon the distribution of a previously fixed total sum of money. Our suggestions for such individual remuneration are given under Item (xviii).

ITEM (xvi)

PARTICULARS OF FINANCIAL STRINGENCY SUFFERED BY ANY CLASSES OF DOCTORS ILLUSTRATED BY PERSONAL BUDGETS OF PRACTITIONERS

I. General Practitioner Principals

(A) **Single-handed Principals with small lists:** We have already indicated under Item (xiii) of this evidence how the capitation system of payment results in doctors with small lists receiving an abnormally small reward for the work they do, and under Item (xi) how this anomaly is accentuated by their practice expenses constituting a larger than average proportion of their gross income. This is particularly true for lists of 500 or less patients, which receive no benefit at all from the loaded capitation fee, and holds good to a certain extent for lists up to 1,500, for it is not until this level is reached that the maximum benefit from loading is received.

A number of actual examples were given under Item (xi), and we should like to draw particular attention to the very low net income remaining after practice expenses have been paid. A few further examples follow.

Examples

(1) Single-handed principal, west London. Number of patients: 620. Total Executive Council income for year (including £302 hardship payments): £947. Other professional income: £68. Total: £1,015. Expenses allowed for income tax: £644. Net income: £371.

(2) Single-handed doctor, country town and country practice, Midlands. Number of patients: 876. Total Executive Council income (including £200 as supplementary annual payment): £1,223. Other professional income: £17. Total: £1,240. Expenses allowed for income tax: £588. Net income: £652.

(3) Single-handed principal, mixed urban and rural practice, south Midlands. Number of patients: 1,050. Executive Council income (including £75 supplementary annual payment): £1,296. Other professional income: £58. Total: £1,354. Expenses: £567 (this does not include £60 for sickness insurance premium, which was not allowed for income tax, but which is a very necessary precaution for a single-handed doctor). Net income: £787.

(B) **Junior Partners:** The N.H.S. regulations make it compulsory for any one member of a partnership to receive not less than one third of the amount of the largest share in the partnership. We believe that this regulation legislates unfairly in favour of the established doctor—the senior partner, who, for example in a two-man partnership, can take three quarters of all the income. In many cases this leaves the junior far from enough on which to support himself and his family, and indeed, though he admittedly has the security of tenure which goes with principalship, the junior may be no better off financially than when he was an assistant. We see no reason why the members of a partnership should not distribute their income on a basis of equal shares, providing that each member does approximately an equal share of the work, and we think that a method of distribution of remuneration should be devised which will enable and encourage such an arrangement without involving undue hardship for any member of the partnership. At the present time it is unfortunately too frequently the case that the senior partner takes the lion's share of the income, while doing far less than his proper share of the work. Often he may be approaching retirement, and doing only occasional surgeries and visits, while his unfortunate junior slaves away, doing almost all the work for a relatively small income, in the hope of succeeding to the practice at some unknown future date. Naturally in such circumstances the senior will continue nominally in practice for as long as possible; and for some reason the circumstances do not generally appear to come to the notice of the Executive Council. In one such instance known to us the senior was in ill health and unable to do any work at all; moreover, the partnership agreement directed that each partner should bear his own car expenses; so the junior had personally to bear the total car expenses for the practice.

A further point which is most discouraging to the junior partner with a small share is that, though he may work hard to augment the practice income by attracting more patients, taking outside appointments and so on, yet his own small share of the additional practice profits is scarcely appreciable.

Examples

(1) Partnership of five, west of England town. Total N.H.S. income. £9,579. Other income: £3,709. Total: £13,288. Total expenses borne communally: £2,203. Total net income: £11,085. Distribution among partners: 27 per cent., 25 per cent., 23 per cent., 15 per cent., 10 per cent. The junior partner of this firm writes: "I entered general practice in January, 1954, as an assistant earning £1,000 per annum, representing a net income of £904. There were no allowances for car, etc. In January, 1955, I became a partner. This made five principals in the firm. I bought a 10 per cent. share in the firm's capital equipment, and received 10 per cent. of the profits. Gross income, £1,032. Net income, £808. In January, 1956, having equipped my own surgery and waiting room, I was awarded a surgery allowance of £250 p.a. Gross income, £1,108 plus £250 = £1,358. Net income, £1,126.

(2) Partnership of three. Junior partner receives one-seventh share, yielding £1,104 p.a., net. (The average income of the other two partners must be treble this amount.)

(3) Junior partner, east London, writes: "Before resolving to take my present post I was offered several really shocking propositions . . . It was only after two years . . . that I discovered what it implied to me and that I had either to take it as offered or to leave it . . . As I could not afford to stay any longer without work, I resolved to take it . . . I then discovered that I was supposed to render between a third and a half of the total work, and that for this I was granted not more and not less than a quarter of a share . . . the Executive Council accepted this agreement as a legally just one." Please see also examples (11) and (12) under Item (ix) of this evidence.

II. Assistant General Practitioners

The earnings of assistants have been fully discussed in our earlier evidence on assistants' remuneration, where we have tried to indicate that the salaries they earn, apart from being insufficient to support a family at a standard of living suitable for a professional man, are quite out of relation to the actual hours worked by the assistants.

As a further example we append the complete analysis of the replies received to our questionnaire sent out in the autumn of 1955 on the question about salary. The figures apply to full-time assistants only, with or without view, and represent the salary (exclusive of car allowance) for the post in which they were employed at the time, or if unemployed, their last previous post:—

<i>Salary—£ p.a.</i>	<i>Number of assistants</i>
600	1
700	1
750	7
800	5
850	21
900	8
950	8
1,000	21
1,050	5
1,100	12
1,150	2
1,200	4

Average salary: £945

Total: 95

To quote some more recent examples, an analysis of 184 vacancies for assistants with or without view where salaries were stated, advertised in the British Medical Journal between May and November, 1957, gave the following results (trainees and part-time assistants were excluded):—

Salary offered	Numbers of Posts in which		
	Salary excludes Car Allowance	Salary includes all car expenses	Advertiser does not mention car allowance
£ p.a.			
750	2	—	—
800	4	—	—
850	5	—	—
875	2	—	—
900	12	2	1
950	4	1	—
1,000	18	28	18
1,050	7	6	8
1,100	2	14	6
1,150	—	9	4
1,200	—	13	4
1,250	—	5	5
1,300	—	1	1
1,350	—	1	1

Though the average salary has risen slightly in the last two years, it is still grossly insufficient, and reflects the state of the medical labour market. Some of these advertisers insert a further advertisement a few weeks later, thanking the many applicants, apologising for being unable to reply to them all individually, and informing them that the post is filled. These are by no means always for the very attractive jobs. It should be noted what a large proportion of principals expect their assistants to pay the whole cost of running a car for the practice out of a gross salary of £1,000 or less. The car allowance, where quoted, varies between £100 and £200 p.a., the usual figure being £150, but we can hardly doubt that, when making their own income tax returns, most of the principals themselves claim considerably more than this amount on account of their own car expenses.

It is only fair to add that in the majority (but by no means all) of the instances where a low salary is offered (up to £1,000 and in a few cases higher), accommodation is provided free for the assistant and sometimes for his family. In most cases the assistant is lodged over the surgery, conveniently placed for taking all calls at night time or other inconvenient hours. So the provision of free accommodation for the assistant is not necessarily without its compensations to the principal (who can claim tax relief on its cost). Several assistants have written to us in the past complaining that the accommodation provided for them was most unsuitable.

We should like to expand a little further on the subject of the assistant's accommodation. Even where this is provided free, it continues only so long as does the assistantship post. If the employment is terminated for any reason, the assistant is then out on the street, unless he can be temporarily housed with relatives, until he finds another job; and jobs are hard to find. Therefore assistants, especially those with wives and young children, tend to remain on in a post the salary and conditions of which they may not like, rather than risk being rendered homeless: just one further example of the powerful bargaining position of the principal, and conversely the weak one of the assistant.

In many cases, however, the assistant is expected to provide and pay for his own accommodation. Unfurnished houses to let are notoriously scarce, and the alternatives may be to live permanently in hotels, to rent expensive furnished accommodation, or to buy and sell houses with each change of assistantship post.

Example.—Unmarried assistant, having to support and maintain mother in own house. Assistantship salary: £1,150 (more than average). Expenses: Hotel accommodation, £7 7s. 0d. per week (£382 p.a.). No other accommodation available, no security of tenure, so permanent home must be kept, no tax allowance on this. Car expenses (the only allowance for tax purposes): approximately £180 p.a. Net income, £588 approximately.

In this connection, it should be mentioned that the salaried assistant does not have the advantages enjoyed by the principal with regard to expenses allowed for income tax. He can claim little more than his car expenses (where no car allowance is given) and his medical defence subscription. Items such as subscriptions for other medical organisations and medical journals are not allowed, not being a condition of employment. No allowance can be claimed for accommodation.

III. Junior Hospital Medical Staff

The low salary scales of all grades up to and including Senior Registrar are known to the Royal Commission and need no elaboration from us. The obvious fact that these doctors were being grossly underpaid was realised by the Prime Minister when, in the spring of 1957, he awarded an immediate increase of 10 per cent. in the remuneration of doctors in these grades, pending the findings of the Royal Commission.

This increase has brought but little relief to the junior grades of house officer, and even the salaries of registrars and above are still far from sufficient either to maintain an adequate standard of living, or in relation to the responsibilities undertaken.

Considering the hours of work (including on-call duty, when they have to be continuously available for emergency), house officers are probably the lowest wage earners per hour in the country. To take as an example a pre-registration house officer in his first post: Salary £467 10s. 0d. p.a. Deducting board and lodging charge of £125 and 6 per cent. superannuation contribution of £28, the net earnings actually received are £342 10s. 0d. p.a. (From this, National Insurance is deducted, over £17 p.a., also income tax if liable.) Actual pay per week: £6 1s. 0d. (on which a family may have to be supported). Assuming off-duty to be, in a typical case, one half-day per week from 1 p.m. to 9 a.m., and one week-end per fortnight from 1 p.m. Saturday to 9 a.m. Monday, the average weekly hours worked are 126. Rate of pay per hour: Under 1s.!

Not until the third year, as S.H.O., does the gross salary reach anything like reasonable proportions, but by that time the responsibilities are far greater, and merit considerably more remuneration than is paid at present.

ITEM (xvii)

SPECIAL CONSIDERATIONS OF WHICH ACCOUNT OUGHT TO BE TAKEN IN
DISCUSSION OF MEDICAL REMUNERATION

The length of the doctor's training, the special responsibility attached to the care of the health and lives of human beings, the need for continuous post-graduate learning, the risks to the doctors own health arising both from the strenuous existence he often has to lead and from contact with infectious illness, and in the case of general practitioners the unique responsibility of having to provide a service which is available 24 hours a day, 7 days a week, all the year round, are all factors which are well known.

We believe that a doctor's income should provide a standard of life commensurate with his value to the community, and corresponding status, and should afford him time for study and for maintaining cultural standards.

ITEM (xviii)

SPECIFIC PROPOSALS FOR MEDICAL REMUNERATION

I. General Practitioner Principals

Our main positive proposals provide for (1) a Basic Expense payment for each practitioner; (2) Increments for Length of Service in the N.H.S.; and (3) Modifications in the Capitation Fee associated with Progressive Reductions in the Maximum Number of Patients per Practitioner.

For the reasons given under Item (xiv) we are opposed to the Central Pool method of distributing remuneration, which we believe should be precise for each individual. We therefore propose the abolition of the annual Final Settlement payments and of income derived from the presence of a new entrant to general medical services.

Remuneration Proposals

(1) **Basic Expense Payment.**—We propose a basic expense payment of £250 p.a. for each practitioner. We believe this is required to help pay for minimal practice expenses; to help to prevent underpayment by the N.H.S. for work done in the case of doctors with relatively few N.H.S. patients; and also to diminish to some extent the excessive competition for "units" resulting from the capitation fee method of remuneration.

We would suggest that the basic expense payment should not be paid to doctors with limited lists who have no practice expenses; that it should be reduced for doctors relieved of any responsibilities under the N.H.S.; and that it should be progressively reduced annually, if necessary eventually to zero, in the instances of very small practices failing to grow, *provided the restrictions on free change of N.H.S. doctor are removed* (it being clearly unjust to penalise the doctors concerned under the existing unfair conditions of competition). (See Associated Proposals (3).)

Each new principal would thus automatically increase the cost of the service by only £250 p.a. (excluding any extra money required for "notional loadings" in the case of new partnerships, and I.P.A. payments), as compared with the present amount of over £3,000 p.a.

(2) **Increments.**—We believe that annual increments are justified in a publicly organised health service. This would, as with the basic expense payment, have the advantage of loosening to some extent the present tight connection between "units" and remuneration. We would suggest a full incremental rate of £25 p.a. for 20 years, making a maximum of £500, with seniority starting from the inception of the N.H.S. For simplicity, we are assuming that the suggested scheme would be introduced precisely ten years after the beginning of the N.H.S.; hence doctors

who would have been engaged as principals in the N.H.S. for 10 years and entitled to full increments for each of these years, would have immediately, in addition to the basic expense payment of £250, an incremental payment of £250.

We would suggest that full increments should be applied to doctors with 1,000 or more patients on their lists for the relevant year (which could be considered to be the average of the numbers of patients at the end of each of the four quarters of the year). Doctors with lists of under 1,000 patients should receive a proportionate amount of the full increment, according to the number of patients on their list, this working out at 6d. per patient per year, making the full increment of £25 for a list of 1,000).

(3) *Capitation Fee: (a) The Standard Capitation Fee:* We believe that increases in the amount of the capitation fee should be associated with reductions in the permitted maximum number of patients per practitioner (see Associated Proposal (1)). We propose that a series of increases in the capitation fee be so arranged that the maximum income from capitation fees, loadings, basic expense payment and increments earnable by an unassisted practitioner with a list of the maximum permitted size should be constant throughout a process of progressive reductions in the size of the maximum list over ten years.

The income from capitation fees and loadings at present accruing from a list of 3,500 patients is £3,637 10s. 0d. To this must be added an amount for the final settlement payment, and for the purposes of our calculation we are taking this as 8 per cent. of the gross income (the amount distributed as final settlement payments for the year 1955-56). Eight per cent. of £3,637 10s. 0d. is £291, so that the total gross income for a list of maximum permitted size is £3,928 10s. 0d. (For simplicity in calculating the capitation fees for our proposed scheme, we are working to an assumed maximum income of £3,925.)

As the first stage in this process we propose an immediate reduction in the maximum size of the N.H.S. list from 3,500 to 3,000 patients, and a compensatory increase in the capitation fee from 17s. 6d. to 19s. 0d. A doctor with a list of 3,000 patients and with the maximum possible seniority (10 years) would thus earn £250 as basic expense payment, £250 as increments, £2,850 as capitation fees, and £575 as loadings (see (b), below), total, £3,925.

Thereafter, we propose that the maximum list size should be reduced at the rate of 100 patients per year for 10 years, giving an eventual maximum of 2,000 patients. Annual adjustments would be made in the capitation fee, bringing it at the end of the 10 year period to 26s. 0d. A doctor with a maximum list of 2,000 patients and 20 years' seniority would then be earning £250 as basic expense payment, £500 as increments, £2,600 as capitation fees, and £575 as loadings, total, £3,925.

Naturally, many doctors would prefer to take others into partnership rather than have their practices reduced in size.

(b) *The Loading:* We do not propose any change in the amount of the loading (11s. 6d.), but if the size of lists is progressively reduced, eventually to a maximum of 2,000, it would be anomalous for the loading to remain on the range 501-1,500 patients, as it would then be extending into the higher range of the list. We therefore propose that the range of the loading be lowered during the 10 year period, eventually to be on the first 1,000 patients, in order to maintain a fair balance of payment for small-list practitioners relative to those with larger lists, since the former would gain comparatively little from the compensatory increases in the capitation fee.

(c) *The Capitation Fee for the Extra List of Patients permitted in respect of the Employment of an Assistant:* We propose that the capitation fee for the patients on the extra list be reduced from the present figure of 17s. 6d. to 15s. 0d., and that the size of this list be reduced by stages, eventually to zero (see Associated Proposal (2)).

Some of the effects of our proposals are shown graphically on the attached loose page. It will be seen that a doctor who has already served 10 years in the N.H.S. as a principal, and with 1,000 or more patients for each of those 10 years

and for the subsequent years, would in 10 years' time earn for the care of 2,000 patients the same (in terms of present-day value of money) as is at present earned for 3,500 patients.

(4) *Other Proposals*: (a) *Initial Practice Allowance*: In view of the proposed basic expense payment of £250, which would be payable to all N.H.S. principals and which we believe should be additional to I.P.A., we do not propose any increase in the present levels of I.P.A. (£750, £562 10s. 0d. and £250 for the first, second and third years respectively).

(b) *Junior Partners*: We propose that it be made compulsory by regulation that no partnership should be recognised by the N.H.S. (e.g., for purposes of notional loading) if any one partner's share is less than one half of that of the largest share in the partnership when that partner first joins the practice; and that a new partner's share should rise so as to reach parity (or near parity) not later than five years from the date of his admission to the partnership.

We further propose that a principal who takes in a partner should be entitled to recover immediately that proportion of any compensation money that may be due to him appropriate to the share of the practice he has transferred. Such a measure might enable some principals to take partners who have hitherto hesitated to do so because they receive no financial compensation for the resulting drop in their income when a partner is taken.

(c) *Maternity Services*: We propose that a doctor whose name is not included on the obstetric list, but who provides maternity medical services for his own N.H.S. patients, should be paid at the same rate for the same work as the doctor whose name is on the obstetric list.

(d) *Rural Practice*: We believe that the special difficulties of rural practitioners, discussed under Item (xiii), justify a special increase in the remuneration of rural practitioners, over and above the present mileage allowance, and that doctors should not be deterred from taking up this type of practice by fear of financial insecurity. We suggest this increase be met either by a higher capitation fee to compensate for the smaller average size of lists (see also Associated Proposal (1) below, in which a reduced maximum list for rural practitioners is proposed), or partly by the latter and partly by paying mileage for *all* patients on a rural practitioner's list (instead of only for patients living more than 2 miles from the doctor).

We also propose that, if the dispensing doctor is to continue to be required to collect the shilling prescription levy (and we consider this an unjust imposition to place on a doctor in any case), then he should be paid an allowance for uncollected shillings, and one at a higher rate than that paid to a chemist.

(e) *Trainee General Practitioner Scheme*: We propose that the training grant to the trainer principal be abolished, as the reward to the principal by virtue of the work done by the trainee is in itself quite handsome.

(f) *Health Centres*: We believe that doctors working in health centres should be paid by a salary or sessional method of remuneration, and in this matter we support the views expressed in the 1944 White Paper on A National Health Service that "It seems fundamental that inside a Centre the grouped doctors should not be in financial competition for patients" and that there is "a strong case for basing future practice in a Health Centre on a salaried remuneration or on some similar alternative which will not involve mutual competition within the Centre."

With regard to the rates of remuneration, we believe these should be at least as favourable as those of practitioners working from private premises.

Associated Proposals

(1) *Reduction of the Permitted Maximum Number of Patients per Practitioner*.—We propose that reductions in the permitted maximum number of patients should be made, eventually to 2,000 per practitioner, for a doctor devoting the major part of his working time to the general medical services. Probably the maximum needs to be lower in rural areas and high morbidity areas, and in such cases the remuneration rate of the doctors affected should be adjusted so as to compensate fully for the lower maxima.

For doctors with a considerable amount of private practice or other non-N.H.S. work, we believe appropriate reductions in the permitted maximum number of patients should be made—in these instances, of course, without compensatory adjustments in the remuneration rate. On this point the 1944 White Paper stated: "A doctor with an unusually large amount of private work, or with appointments in other branches of the public service, will be expected to work to a lower permitted limit".

The reason why we regard the reduction in the maximum size of lists as an urgent necessity is that, in our view, a practitioner is not able to provide the full range of general medical care at an adequate standard of diagnosis and treatment for so great a number of patients as 3,500. The fact that many single-handed practitioners employ assistants casually for the busy months of the year is evidence that they themselves realise that they have taken on more work than they can cope with. For one doctor to look after so many patients inevitably means that his standard of work will suffer, as there is not sufficient time available to devote adequate attention to the many cases requiring detailed history taking, examination, and proper explanation and discussion with the patient of his illness and its treatment.

This subject is considered more fully under Item (xxi), but we append here some extracts to support the view that maximum lists should be smaller than they are at present.

Extracts

"More doctors should be encouraged to become general practitioners; and practices should be made smaller. They could then spend a greater amount of time in consultations (at present brief by Canadian standards) as friend and adviser to their patients." (From "The Pattern of General Practice" by A. G. Richards, B.A., M.B., *The Lancet*, 5th May, 1956.)

"76 per cent. of country doctors do not want to look after more than 2,000 patients. In the towns, the number most popular is 2,500 . . . In the towns I found that 33 per cent. had lists larger than they felt they could deal with satisfactorily, in the country, 26 per cent." (From "A Field Survey of General Practice, 1951-2" by Stephen J. Hadfield, *British Medical Journal*, 26th September, 1953.)

"The conditions of general practice should be such as will give the practitioner the time he needs for each patient." (From the Report of the General Practice Committee of the B.M.A. (based on the Hadfield survey), *British Medical Journal*, 26th September, 1953.)

Referring to the appointment of the Committee on medical man-power: "I hope that the committee will keep well before it the great need for a further reduction in the size of general practitioner lists". (From a letter to *The Times*, 28th February, 1955, from Mr. Arthur Blenkinsop, M.P.)

"No one who looked at the developing pattern of their social scene and of the health services for which it called, could think it likely that the era of expansion was over. There was plenty of room for improvement, in both quantity and quality." (From a report in *The Scotsman*, 16th January, 1956, of a speech by Sir Hector Hetherington, Principal of Glasgow University—quoted in *British Medical Journal Supplement*, 4th February, 1956, p. 34.)

"It has been argued that even within the N.H.S. today there is scope for good work, since the 'good' general practitioner will get a good reputation—and so a big list—while the poor quality general practitioner will get an inferior reputation and so a smaller list. This concept is fallacious. A thorough, conscientious general practitioner is at once at a great disadvantage in comparison with a poor-quality general practitioner for the following reasons: (1) He is unable to examine and investigate many patients in a day compared with his less skilled colleagues. That is, he cannot have a large list unless he is prepared to permit the quality of his work to deteriorate." (Further reasons follow.) (From "Improving General Practice" by R. F. Jenkins, General Practitioner, *British Medical Journal Supplement*, 16th June, 1956, p. 351.)

"The basic fact about bad conditions in general practice is that the doctor has not enough time to do his duty. The Government allots up to 3,500 patients per doctor, ignoring the resultant impossibility of a decent standard of practice. The corollary and the nation's duty is to reduce the figure to 2,500. Experienced doctors know how often things are missed or correct diagnosis delayed through 'not looking'. Curt procedure excludes the mental factor in healing. The precious personal touch entails a few kind words and listening with patience. Lack of time deprives the doctor of the full exercise of his talents, and they tend to atrophy. The patients reap less of the benefits accruing from his long education." (From "Doctors and the Health Service, Twofold Concern" by A. Wilfrid Adams, M.S., F.R.C.S., British Medical Journal Supplement, 4th May, 1957, p. 241.)

With regard to our suggestion that the maximum to be aimed at should be at the most 2,000 patients, we wish to mention the following:—

- (a) The maximum list for a family internist in the Montefiore Medical Group in New York is 1,500, and for a paediatrician, 800. (The Lancet, 6th July 1957.)
- (b) For an adult population of 70,000 people living within a distance of 2 kilometres, Moscow polyclinic No. 71 provides a medical staff which includes 19 section doctors and 11 emergency doctors (British Medical Journal Supplement, 17th August, 1957)—i.e., an average of approximately one doctor doing general practitioner work per 2,300 adult persons; however, we must take into account that some of the work carried out by G.P.'s in this country is borne not by these doctors but by the many specialists attached to the polyclinic, and by the medical staffs at the factory polyclinics.
- (c) Even in China, the average number of patients per doctor may now in selected instances be less than 2,000: "At Shenyang (Mukden) in the industrial North-East, private group practice has been abolished, and they are building municipal health centres. The one we saw looks after some 25,000 (mostly privileged) people, including 5,000 factory workers and others entitled to free medical care, and also their families, who pay half-fees. It is well staffed, with 16 doctors (1 traditional), nurses, laboratory technicians, 4 midwives, and 4 pharmacists, and it has an X-ray department. Doctors visit patients' homes, by bicycle, and one is on call at night." (T. F. Fox, M.A., M.D., F.R.C.P., "The New China", The Lancet, 16th November, 1957, p. 995.)
- (d) We believe the maximum rate of work compatible with a satisfactory standard of medicine to be in the region of an average of 4 services (surgery consultations or visits) per hour for 50 hours per week, that is, 200 services per week, or approximately 10,000 per year. At present the average number of services per patient per year is about 5 (Lancet, 27th April, 1957, p. 881), so that 10,000 items of service per year are required for 2,000 patients, our suggested maximum. Moreover, we believe that the range of services at present being rendered by most general practitioners could with advantage be extended to include not only such items as minor surgery (at present usually referred to hospital), but also greater emphasis on preventive medicine, health education, and the promotion of positive health.

2. Reduction and Abolition of the Additional List of Patients allowed for the Employment of an Assistant.—We believe that the permanent additional list for the employment of an assistant should be abolished as soon as possible. We would suggest an immediate reduction of the maximum by 500, bringing it to 1,500, followed by further reductions at the rate of 300 per year for 5 years. This measure would induce many of the principals concerned to take an assistant into partnership rather than lose the remuneration attached to the patients on the extra list.

Cases could occur where a principal who contemplates taking a partner is uncertain whether the practice will grow sufficiently to enable him to afford to

do so. We therefore propose that, where a practitioner expresses to the local Executive Council his intention of taking an assistant with a definite view to partnership, he should be permitted to have a temporary extra list for a maximum period of two years (subject on appeal, in special circumstances, to an extension for a third year) up to a maximum of 1,000 patients (and at a capitation fee of 15s. per patient on the extra list). This concession would still allow a principal to try out a number of assistants, should the first one or more prove unsatisfactory.

3. Abolition of the Restrictive Regulations on Change of Doctor.—We believe that the restrictions on free change of doctor discriminate unfairly against both doctors with small practices and patients cared for exclusively by the N.H.S. We have no doubt that these restrictions protect the large practices, and believe that this is the real reason why "the profession" urged them on the Ministry of Health in the first place. These restrictions act as a brake on the natural development of the newer practices. With regard to the patients, only the relatively wealthy need not hesitate to go to another doctor privately (and hence are not subject to restrictions), so the restrictions in reality apply only to the majority of the population; we consider this, too, an unfair discrimination in the N.H.S.

II. Assistant and Trainee General Practitioners and Locums

We believe that a trainee general practitioner in his first year in general practice should earn the equivalent of £500 per annum in terms of 1939 prices. (This figure was recommended in the Spens Report on general practitioner remuneration.)

We have proposed elsewhere (vide our earlier evidence on assistant general practitioners) that an assistant's statutory minimum salary should be based on a 5½ day working week, with additional remuneration for night work and work at week-ends and public holidays. We suggest that the statutory minimum salary should be not less than £20 per week, clear of all expenses, and with living accommodation provided for the assistant, or a living out allowance sufficient to cover its cost. We further suggest that rates of remuneration for hours worked in excess of the standard week be so calculated that with reasonable "overtime"—say, duty on alternate nights and alternate weekends—incomes substantially above this salary should be earned.

With regard to the salaries of locums, we believe that if a Wages Council (or equivalent) for Assistant General Practitioners is formed, such a body should include consideration of this matter in its work.

III. Hospital Medical Staff

Under the existing hospital staffing system, the only permanent medical staff in the hospital service are Consultants and S.H.M.O.'s.

We believe that it should be possible for a doctor to choose to follow a career in the hospital service without necessarily having to reach the top rank. Before the inception of the N.H.S., the medical staffs of local authority general hospitals were able to obtain permanent posts below the grade now known as Consultant, and we think that this system is preferable to the present one. The latter is wasteful of medical man-power, because at each stage of promotion the number of vacancies is reduced, and a number of men who have had years of specialised training, and probably with higher qualifications, are forced out of the hospital service.

We would like to suggest to the Royal Commission a possible scheme for graded career posts in the hospital service, as follows:—

- (1) *House Officers*—posts for six months or one year.
- (2) *Hospital Medical Officers*—hospital career posts made up from present J.H.M.O.'s, Registrars and Senior Registrars who have not yet completed 4 years in that grade.
- (3) *Specialists*—made up from present S.H.M.O.'s, Senior Registrars who have completed 4 years or more in that grade, and relatively junior Consultants; and later recruited from suitable candidates from (2).

- (4) *Senior Specialists*—present senior Consultants; and later recruited from suitable candidates from (3).
- (5) *Consultants*—eminent or leading Consultants, mostly after retirement from routine hospital work; and later recruited from senior members of (4).

We would suggest the following rates of remuneration for wholetime hospital medical staff, for the grades proposed above. Our proposals are based loosely on the report of the Spens Committee on the Remuneration of Consultants and Specialists, by doubling the salary range of £600 to £1,200 recommended in it in terms of 1939 prices for the medical staff between the grades of house officers and specialists.

- (1) *House Officers*: For pre-registration house officers, £600 p.a. for first post, £700 p.a. for second or subsequent post. Following completion of the pre-registration year, £800-£1,000 p.a.
- (2) *Hospital Medical Officers*: £1,200 p.a. rising to £2,400.
- * (3) *Specialists*: £2,600 (at age 32), rising to £4,000.
- * (4) *Senior Specialists*: £4,500 to £5,000 or more.

The suggested salary scales for Specialists and Senior Specialists are intended to be inclusive of what at present is paid as merit awards, but which, in our view, would probably be better met by the creation of Responsibility Awards attached to particular posts (instead of, as at present, to particular anonymous individuals).

* For part-time Specialists and Senior Specialists: $\frac{x}{11}$ only of the whole-time salary, where "x" is the number of sessions. The number of weekly sessions for a part-time hospital doctor should be limited to a maximum of, say, 6 or 7.

IV. Adjustments in Remuneration

All the proposals made are in terms of present-day prices. They do not, of course, preclude negotiated future adjustments for changes in the value of money. In the case of general practitioners there should, in addition, be arrangements for annual adjustments in respect of changes in the cost of specific items of practice expenses, e.g., petrol, telephone charges.

ITEM (xix)

THE PRACTICABILITY OF THE PROFESSION ESTABLISHING A FIXED SCALE OF PAYMENT FOR ASSISTANTS IN GENERAL PRACTICE

In our view, such an arrangement is definitely not practicable. In Section IV of our earlier evidence on assistants' remuneration we gave a summary of the abortive attempts made over the past seven years by this Association to secure for assistants effective negotiating machinery through the B.M.A. or the G.M.S.C.

The need for establishing statutory minimum salary scales and conditions of employment is nevertheless urgent and great. As we have tried to show, both in our earlier evidence on assistants' remuneration and under Item (xvi) of this evidence, the salaries and conditions of service of assistants cannot under existing conditions be left to adjust themselves by the natural laws of supply and demand. Owing to the large surplus of doctors unable to enter practice as principals, an excess of potential assistants is available, and it is not necessary to offer either a fair salary or attractive conditions in order to attract scores of applications for a post from well qualified applicants.

In our opinion there should be laid down statutory minimum rates of pay for assistants based on a fair working week, with additional remuneration for overtime working. Such rates cannot be laid down by the profession, whose leaders represent the employers themselves: it must be done by an outside body such as a Wages Council.

Under Item (xvi) we gave a number of examples of the relatively low salaries earned by assistants. In this section we should like to elaborate this point by quoting examples of the way in which many principals overwork their assistants

by giving them, not half the work of the practice (even this would often be considerably more than their salaries are worth), but frequently the majority of the work.

Examples

(These are taken from personal letters written to us by assistants themselves. We have many other examples on our files.)

(1) "The G.P.R.A. might be interested in my former employment. I worked for 2½ years as full-time assistant in a large practice consisting of 3 principals and 2 assistants. Principal No. 1 did a few surgeries. So did Principal No. 2, plus a few calls. Principal No. 3 (who worked part-time) made up her salary by doing all the midwifery. Assistants Nos. 1 and 2 did all afternoon, evening and night duties between them, 365 days a year, holidays included."

(2) "I am at present in the process of leaving a post of assistant with view because of the appalling house in which the assistant (who does 90 per cent. of the practice work) is expected to live."

(3) "Details of previous post held between 1952 and 1954: The practice of 4,000 patients was in the hands of a principal who not only did not run the practice but was incapable due to ill health. There was no view from the outset . . . I was responsible for doing all calls, night and day, seven days a week except every third week-end and three weeks per annum paid holiday when a locum was employed. I was responsible for receiving messages 24 hours a day when off duty as well as on, and even when on holiday. I was responsible for accommodating any locum who might not live locally. The only work my principal did was odd surgeries during the week. The 'assistant' virtually ran the practice."

(4) "In the Rhondda, which I chose for gaining industrial experience, the treatment I received was disgraceful. My principal was, I hope, a singularly bad type, but the treatment I received was not unusual. At a preliminary interview I was quite misled. Salary offered was £1,200 p.a. including car allowance, but expenses were fantastic. Keeping a resident housekeeper and persuading her to help out with 24 hour phone cover was nearly ruinous. . . . Off duty frequently failed to materialise and after a period of one week's sickness the principal deducted the sum paid to me by the . . . Company on my personal sickness policy from my cheque. . . . I was expected to account for every minute of my off duty and was subjected to sudden visits or phone calls at any time up to 2 a.m. by the doctor or a member of his family. He in fact was frequently absent from the practice even when 'on duty'."

(5) "The traineeship I did in N.W. London was nothing more than free labour for a principal. I did all the N.H.S. surgeries except one per week and over 50 per cent. of his N.H.S. calls, which left him time to devote himself to increasing private practice. . . . A traineeship of this kind is nothing but abuse of the Health Service and is highly condemnable."

(N.B. Please see our remarks on trainer principals under Item (xiii).)

(6) "Trainee-assistant scheme is iniquitous. I worked for 10 months as a trainee-assistant to a principal with list of 3,500. I had to run the surgery and N.H.S. list almost single-handed. Principal even tried to make me pay the whole of the National Insurance stamp, as 'he was not reimbursed by the Executive Committee for this'. I disapprove of this scheme because the principal is getting the services of an assistant free of charge and the training was noticeable by its absence."

(7) "Assistant since Oct., 1954, formerly 'with view'. Urban practice, 3,800 patients. One principal (on obstetric list). I conduct single-handed three of the four surgeries daily, two of them at . . . Health Centre; attend all the 30-40 midwifery cases. Do all night calls, all rota duties (once a week 8 p.m. to midnight for 15,000 patients, every sixth week-end for 15,000 patients), and all emergency calls. . . . Do 50-75 per cent. of the daily visiting. . . . Weekly half-day, 1 p.m. to midnight. . . . Except for a few (four to five at most) visits on Saturday mornings the principal has virtually a 4½ day week in his general practice. . . . Of the general

practice . . . I do two-thirds to three-quarters of the work. The total N.H.S. income of the practice is in the region of £2,800. Two-thirds to three-quarters of this is £1,860-£2,100. My gross income is £1,000 (plus car allowance)."

ITEM (xx)

PROPOSALS FOR SPECIFIC MACHINERY OR PROCEDURES TO BE ESTABLISHED FOR DEALING WITH FUTURE DISCUSSIONS OF MEDICAL REMUNERATION

I. For Hospital Medical Staff.—We propose that existing Whitley machinery be continued, but that the Staff side should be made fully representative directly of whole-time consultants, senior hospital medical officers, senior registrars, registrars, junior hospital medical officers and house officers as well as of part-time consultants, and should not be dominated by consultants from the teaching hospitals.

II. For General Practitioner Principals.—Whitley machinery, as is provided for on paper, should be established, and the staff side should be genuinely representative of different groups—e.g., small, medium and large list practitioners, single-handed and partnership practitioners, urban and rural practitioners (i.e., it should not consist predominantly of nominees of the G.M.S.C. or the B.M.A.). The Management side should include adequate representation of representatives of the Ministry of Health (the Government thereby having no reason for failing to accept an agreement reached in Council).

III. For Assistant General Practitioners, Locum Tenens General Practitioners and Trainee General Practitioners.—A Wages Council, or an equivalent body under the Ministry of Health and the Department of Health for Scotland, is the only satisfactory and equitable solution, in our view.

(Please see our reasons in Section IV of our earlier evidence on Assistants.)

ITEM (xxi)

ANY FACTORS OTHER THAN REMUNERATION WHICH ARE AFFECTING THE CONTENTMENT OF GENERAL PRACTITIONERS

We believe it is essential to distinguish between the *manifestations* of the malaise of general practice and their basic *causes*.

In our opinion the main *causes* of the unsatisfactory state of general practice in this country may be summarised as follows:—

1. There is insufficient time available per patient, resulting in rushed consultations and visits, due to the excessively high maximal size of the N.H.S. list of patients. The present method of payment rewards quantity at the expense of quality of work.
2. Financial competition between doctors for N.H.S. patients. As a result of the necessity to acquire as large a list as possible, the onus of maintaining standards of medicine at a high level is, in effect, thrown on the patient, who, having no medical knowledge, is not necessarily the best judge of the doctor. The doctor, on the other hand, has to reconcile his professional conscience with his desire to satisfy his patients' requests, for fear that, if the latter are refused, the patients will go elsewhere to obtain what they want. Hence the fostering of the "bottle of medicine habit", with consequent relatively high cost of the national drug bill, and in many cases lax certification of incapacity due to sickness.
3. Lack of capital investment programme for the development of general practice (provision of fully equipped and staffed health centres).
4. Lack of secretarial and nursing assistance, because of lack of financial resources.
5. Insufficient time and opportunity for postgraduate education.
6. Paucity of domiciliary medical teams with individual specialisation within the field of general practice. The *completely* all-round G.P. is an anachronism today, because of the tremendous technical advances in medicine.

7. Administrative and practical separation of general practice from the hospital service and the local health authority services. (For example, most general practitioners are unable to do hospital work.)

The outward *manifestations* of these various factors consist mainly in an appallingly low standard of general practice in far too many cases. History taking and physical examination tend to be hurried and inadequate and treatment to be largely confined to the issuing of prescriptions, frequently on the basis of a prescription for each symptom of which the patient complains. Cases which appear to require more lengthy examination or investigation are referred to consultants in hospital, and many minor surgical procedures, which could easily be carried out by the G.P. if he had more time and incentive, are referred to the Casualty Department. Little attention is devoted to the study of the patient's social and psychological background, yet this is essential to the assessment of the real significance of symptoms and to the understanding of the full implications of most illnesses for which patients consult their general practitioners. With regard to the promotion of health, this does not even enter into general practice in this country.

We could enlarge on this theme at length, but will confine ourselves to giving some quotations to illustrate some of the points we have made.

Extracts

On low standards of practice

"The present state of general practice is unsatisfactory. . . . For several decades general practice has adapted itself to the growth and development of hospital specialist, and other medical services; but it has not developed concurrently." (From "General Practice in England Today, a Reconnaissance", by Joseph S. Collings, *Lancet*, 25th March, 1950, p. 555.)

"In fact, under prevailing conditions of industrial practice, anything approaching a general or complete examination is out of the question; examinations are usually confined to the offending organ, and even then are cursory. Certain routine procedures are followed, almost religiously: throats and tongues are looked at, pulse rates and temperatures are taken, and chests are 'listened to', either at the patient's request or for some specific reason. (The process of 'listening to' must not be confused with chest examination: it consists merely in applying the stethoscope to some area readily exposed by unbuttoning a shirt or pulling down an under garment.) On urgent indication an abdomen may be palpated: I have often seen this done with the patient standing, and I have rarely seen what could be termed a thorough abdominal examination made in an industrial practice." (*Ibid.*)

"Treatment is even more restricted than diagnosis. Most of it is symptomatic, and nearly all of it is medicinal; for there is neither time nor opportunity for physical therapy or psychotherapy." (*Ibid.*)

"The over-all state of general practice is bad and is still deteriorating." (*Ibid.*)

"It was interesting to note how rarely inspection and percussion are used in examining the chest. . . . I was surprised at the prevalence of the method of examining the abdomen through the clothes with the patient standing." (From "A Field Survey of General Practice", by Stephen Hadfield, *British Medical Journal*, 26th September, 1953.)

"In a substantial number of practices, lack of time has reduced the range of service the practitioner can give to his patients." (*Ibid.*)

"The haste necessitated by crowded surgeries was said to induce mental fatigue and strain, diminish alertness of mind, and cloud clinical judgment. This led to a tendency to 'spot diagnosis' and to the reference to hospital of any cases requiring much thought." (From "A Postal Enquiry among 12,879 G.P. Principals, July 1951", by Stephen Hadfield, *British Medical Journal*, 26th September, 1953.)

"... some ten million people living mostly in industrial areas are receiving from their 5,000 doctors a medical service which leaves much to be desired." (From "Comment" in *The Observer*, 28th March, 1954, on findings reported in "Good General Practice" by Stephen Taylor, Oxford University Press, 1954.)

"In ventilating this subject, one is bound to contrast these stories with those of doctors who complain that they are overworked and have no time to see their patients." (Dr. Donald Johnson, M.P., speaking in the Adjournment Debate on 24th April, 1956, on the subject of medical unemployment.)

"I know what fine work general practitioners perform and how essential they are, but the constant demand on their services, the lack of leisure to pursue their studies in the rapidly advancing fields of modern medicine, gradually turn many into prescription-writing and form-filling automata, whose days are spent in seeing the largest number of patients in the shortest possible time." (From "Doctor on the Dole", by Michael Johnn, Christopher Johnson Ltd., 1957, p. 153.)

"One G.P. put it cynically: 'All you need is a good ball-point and a prescription pad.' . . . As the practice of a high standard of medicine and surgery in general practice costs both time and money, any G.P. attempting to do good work is at once at a disadvantage compared with the G.P. who sends to hospital, at considerable cost to the N.H.S., all patients whom he thinks may be sick." (From an article, "What Makes a Good Doctor Today?", News Chronicle, 6th July, 1956, quoting extracts from correspondence in the British Medical Journal.)

"I have this afternoon seen three cases in which the patient said that she had never been examined by her doctor, and this is by no means unusual. One letter said, 'Jumar pain'. It is dispiriting to see so many people sent to hospital not for advice but apparently to get them out of the surgery with as little work as possible . . ." (From a letter from a consultant to the Editor, The Lancet, published 3rd August, 1957.)

On the need for more refresher courses for general practitioners, and for more nursing and secretarial assistance

"79 per cent. of G.P.'s would like more time for refresher courses to bring themselves up to date. They are conscious of the gap between hospital standards and those that have been forced upon them by the N.H.S. But at present they are powerless to catch up. For the same reason 58 per cent. of the G.P.'s feel that they would be able to render a better service if they had more secretarial help, and 54 per cent. if they had a nurse in the surgery. At present any doctor who employs help of this kind has to pay for it himself out of the 17s. a year he gets paid for looking after each patient. It is not surprising that few do have any skilled help apart from a long-suffering wife." (From the article in the News Chronicle, 6th July, 1956, above referred to, giving some results of a Gallup Poll of general practitioners.)

On the need for specialisation within the field of general practice

"The development of a special interest by a general practitioner is not to be discouraged; indeed in a group practice it is desirable, and in rural practice additional knowledge is always useful. It should, however, be understood that the interest should be within the scope of general practice." (From "General Practice and the Training of the General Practitioner", published by the B.M.A., 1950, p. 23.)

On the need for more health centres and for unified administration of the health services

"He (Professor Fraser Brockington) believes that the right place in which, and from which the practitioner should work is a health centre, which could give him the scientific and the social instruments for a modern approach to health, and also the advantage of team-work . . ." (From an Editorial Article in The Lancet, 28th April, 1956.)

" . . . there must be many hundreds of good local authority clinics which could be used with advantage by general medical practitioners without necessarily curtailing the local health authority services. (From "The William Budd Health Centre", British Medical Journal, 13th February, 1954, p. 391.)

"Our health service, as we have it today, is divided into three parts, administered by unconnected authorities: the general practitioners, the hospital and specialist services, and the local authority services. Whether or not the Guillebaud Committee

will come to any conclusion for altering this division, I suggest that the natural and easy way of bringing about the co-ordination of all these different elements is to get the local work of the Health Service done in health centres, where all of them are to be found." (From "The Role of the Individual in Health Service", by Lord Beveridge, *British Medical Journal*, 11th September, 1954, p. 1373.)

"In my opinion a more serious weakness of the present structure lies in the fact that the National Health Service is in three parts, is operated by three sets of bodies having no organic connection with each other, and is financed by three methods one of which differs radically from the other two." (From "Reservation about the Structure of the National Health Service"—minority report of Sir John Maude, from the Guillebaud Committee report on N.H.S. costs, January, 1956, p. 276.)

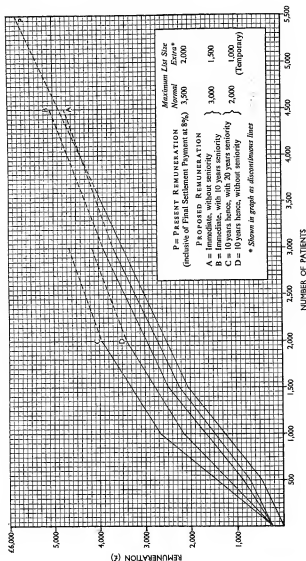
"Perhaps the greatest problem of the service, he continued, was the tripartite division of the administrative structure. . . . It was in the home health and preventive services, Mr. Turton thought, that the tripartite administrative structure raised most problems. . . . In his view health and welfare were so closely linked that in the domiciliary field at least they ought to be administered as one." (Parliamentary report in *The Lancet*, 12th May, 1956, reporting Mr. Turton's speech on 7th May, in opening a debate on the Guillebaud report.)

"The National Health Service Acts placed community care under the local health authority and hospital care under the Ministry of Health. By this division the services designed to preserve the health of the citizen in the community are separated from the treatment offered him in hospital. Sometimes this administrative independence is unimportant—e.g., when the local health authority deals with sanitation and the hospital service treats a fracture in a healthy patient. But more often it is impossible to separate the citizen from his disease. This is especially true of the psychiatric patient: care and treatment must be given to him both in the community and in the hospital, and it should be given without interruption." (From "An Integrated Mental-Health Service", by Duncan MacMillan, M.D., B.Sc., F.R.C.P.E., D.Psych., *Lancet*, 24th November, 1956, p. 1094.)

"... the movement towards merging of clinical and community medicine—of curative and preventive medicine—will render the tripartite structure of the National Health Service out of date." (From a report in *The Lancet*, 5th January, 1957, p. 42, of the Malcolm Morris Lecture on Clinical and Community Medicine by Dr. J. N. Morris on 6th December, 1956.)

Please see also the extracts given under Associated Proposal (1) of Item (xviii) of this evidence, remuneration of general practitioner principals.

G.P.R.A. Remuneration Proposals for General Practitioner Principals

(All money figures in terms of present-day value)

Examination of Witnesses

DR. A. C. J. SAUDEK, *Chairman, Executive Committee*

DR. H. P. HILDITCH, *Secretary, Executive Committee*

DR. L. RUSSELL

DR. J. J. SEGALL

on behalf of the General Practice Reform Association,

Called and Examined

2182. *Chairman*: Dr. Saudek, you are the Chairman of your Association and the principal spokesman?—*Dr. Saudek*: Yes.

2183. You have sent us a great deal of evidence in two lots of documents; the first one was in two parts, so you may not always be sure just which one we are referring to. We are not going to go through the whole of your evidence. A great deal of it has been covered by submissions from other bodies, and we are going to concentrate on a few special matters of interest to the Commission. I hope you will understand that we wish to test what you have said quite thoroughly and will want to ask many questions. I do not want you to regard that as implying either disbelief or hostility, nor that we feel it necessary to make reference to any particular points in our Report. Indeed, failure to pursue a point does not necessarily imply either that we have rejected it or that we have accepted it. Every member of the Commission will be asking questions of you, but for convenience we have divided the task of sifting the very voluminous submissions that we have received from many bodies between two sub-committees of the Commission. Sir David Hughes Parry has been Chairman of the sub-committee that has dealt with your evidence, so that he will be leading off with questions on most of the topics, although any member of the Commission may ask you subsequent questions.

First of all, I would like to know for the record a bit about your membership and coverage, whom you represent and what. Could you tell me briefly?—We were founded in 1950 under another name, the Unestablished Practitioners Group. At a Special General Meeting in 1954 the name was changed by majority vote to the present name, the General Practice Reform Association, and scope of the policy of the Association was enlarged. We have 200 members. We have a subscribing

membership of 200, and in addition to that we have what you might call an Associate Membership—they are not subscribing. They number over another 200; they have an interest in our work, and they have asked to receive our literature and do receive our literature regularly, but they are not allowed to vote at meetings or propose resolutions at meetings.

2184. Do you cover primarily the younger doctors?—Yes, I would say so.

2185. Will you tell me to what extent you cover the two main branches of the profession, the hospital side and the general practitioner side? Your title now implies general practice.—We are mainly general practice. About 50 per cent. of the members are principals—small list principals—about 45 per cent. are assistants or locums, and about 5 per cent. are in other branches of medicine, hospital, Public Health and industry.

2186. From all over the country?—Yes.

2187. Are they well distributed?—Oh, yes.

2188. *Sir Hugh Watson*: Including Scotland?—Including Scotland, yes.

2189. *Sir David Hughes Parry*: Dr. Saudek, may I take you to your recommendations of specific proposals for medical remuneration? We are greatly interested in the proposals that you have made on page 424 and onwards. May I start with the matters concerning the unestablished doctors? I would like to take page 430, item (ix), and then work backwards from that. In your second paragraph you say: "Owing to the large surplus of doctors unable to enter practice as principals, an excess of potential assistants is available. . . ." You say a large surplus; have you any figures as to those who are unable to enter practice?—Well, there are, of course, the figures of the Ministry of Health of the number of assistants in the

country—1,500 or 1,546 I think was the last figure. I have no actual figures of the total, including locums and casual workers and that sort of thing.

2190. You would agree that a number of those perhaps do not desire to become principals? They aspire for the time being at any rate to remain as assistants?—No, I would not agree with that.

2191. You think that everyone aspires to be a principal?—Once they enter the general practice field, yes, as a rule. There must be very few who want to remain assistants all their lives.

2192. *Chairman*: But you are not suggesting that all the 1,546 assistants are people who should now be principals?—Who should now be principals?

2193. Yes.—No, not all of them.

2194. Not even a very large proportion. But are not most of these people at the assistant stage?—I am not including in that figure the number of trainees. They are the people who are on the way through. They are gaining experience in general practice, and we feel it should be possible in a reasonably short time after completing traineeship to obtain principal status.

2195. *Sir David Hughes Parry*: Then you go on to complete the sentence—and it might be misleading if it is taken out of its context: "and it is not necessary to offer either a fair salary or attractive conditions in order to attract scores of applications for a post from well qualified applicants". That is liable to be misread. You would like there to be, would you not, offered a fair salary and attractive conditions?—Yes.

2196. That is a dangerous sentence if it is taken out of its context, is it not?—You mean it is badly put, Sir? What we meant was that the supply of potential assistant labour is in excess of the demand, and therefore people are going to get any kind of a job rather than go unemployed, and will accept offers of sub-standard salaries.

2197. Your suggestion to meet that is contained in the third paragraph of that section, that "there should be laid down statutory minimum rates of pay for assistants based on a fair working week. . . ." I wonder if you would expand that a little bit? We are not quite certain what you were driving at there.—Could I ask Dr. Segall to say

a word, Sir?—*Dr. Segall*: We have in mind something on the principle of the Wages Council. Perhaps I should say right at the outset that such a policy was first put into our minds by officers of the Ministry of Health when we met them, in 1951 I believe it was, and the question of the conditions of employment of assistants was discussed. The view of the officers at that time was that the Ministry of Health could not do anything about it. But it was mentioned en passant, as it were, by one of them that the only possible method that they could envisage was a Wages Council. But we do not necessarily need a Wages Council as stated in the Wages Council Act. That would perhaps be a possibility. We also thought of some similar machinery under the Ministry of Health.

2198. Thank you. You have cleared that up. There is one general point. One feature of a profession always is that it tries to manage its own affairs without any undue interference from outside, does it not?—Yes.

2199. This cuts a little into that, does it not?—Well, possibly, but we think with good reason. That idea, having been put into our minds in 1951, we did nothing about it for about five years. We explored the other avenues, and I think it was two years ago we came to the conclusion that we would not get satisfaction along those avenues within the profession; we tried more than once. So we thought we would sound the views of those members who are assistants and of other assistants to see what they thought about it.

2200. *Chairman*: Are you an assistant?—No.

2201. You are an established practitioner?—Yes.—*Dr. Russell*: May I add to that to amplify it, that some of us here have served on the General Medical Services Committee of the B.M.A., and particularly on the Unestablished Practitioners Sub-Committee. I was for three years a member of the General Medical Services Committee. We were particularly interested in this problem, and it was only after repeated meetings with the Assistants and Young Practitioners Sub-Committee, and after we had pressed the General Medical Services Committee for considerably more than three years, in fact since 1950, that finally the General Medical Services Committee decided

there was nothing unethical or improper, to use their own words, in a principal enjoying a monetary award for the permanent employment of an assistant. It was only following their decision on that basis and as we considered it was not really a true statement and not in keeping with the professional relationship of the assistant and principal, that we decided to explore the possibility of a register or some similar arrangement.

2202. *Sir Hugh Watson*: Many professional persons employ assistants.—Not in a nationally organised service.

2203. Is that anything to do with it really?—We think so.

2204. Your complaint, as I understand it, is really not against the Health Service at all but against the senior and established members of your own profession who, you say, persist in giving inadequate remuneration to the assistants whom they employ?—It is, of course, very closely tied up, though, Sir, with the authorisation under the National Health Service of an extra list for the employment of an assistant. In fact, the Health Service encourages a principal to acquire a very large list and employ an assistant rather than take a partner.

2205. Well, it permits it.—It permits it, and in some ways financially encourages it.

2206. Can you tell us how a practice now differs in this respect from what it was before the introduction of the National Health Service?—It differs in so far as previously assistants were able to buy a share of the partnership.

2207. Wait a minute now. We have not got to the question of partnership yet; we are still talking about assistants. May I take it that before the National Health Service was introduced general practitioners employed assistants?—Oh, yes.

2208. And I suppose they profited, as you put it, from their employment. The assistant was paid a salary, but the doctor drew the fees?—That is so.

2209. *Chairman*: Is it not the case, Dr. Russell, that when a doctor takes an assistant for the first time it is most unlikely that he will thereby immediately increase his list by considerable dimensions?—It is most unlikely, yes.

2210. And he is not going to profit very much if he is paying an assistant,

say, £1,000 a year and getting an extra 100 patients in the first year. He will in fact be out of pocket considerably?—Well, Sir, if one assumes that the assistant is only doing the work of the extra list. But in fact in practice we find that the assistant usually does something like, at a conservative estimate, half the work of the practice.

2211. *Sir Hugh Watson*: Have you got any statistics to prove that?—*Dr. Saudek*: We have had a number of letters from assistants who have said so.—*Dr. Russell*: We have given some figures in our evidence.

2212. You have given us half a dozen examples, but there are 1,546 assistants, from what Dr. Saudek said to Sir David. And according to my information there are 26,000 practitioners in the National Health Service. In my rough calculation assistants represent something less than 7 per cent. Now, can it be that all these 1,500 are victims of these conditions that you portray?—There are 1,500 assistants in England and Wales and 20,000 principals in England and Wales. We got figures in on questionnaire enquiry from 113 assistants, I think it was.—*Dr. Saudek*: 113 returns.

2213. *Chairman*: How many did you ask?—We sent out about 1,000.

2214. And you got about an 11 per cent. reply?—Yes.—*Dr. Hilditch*: I have got the results of that questionnaire here. We got 111 usable replies altogether, and we sent out about 1,000 forms. Of course, we have not any formal statistics in the sense that you would probably ask for them. I do not think any have ever been published, but we have had to base our conclusions partly on this questionnaire, partly on the verbal and written communications of our own members, partly on our own experience, and partly on various other publications, such as two articles on the unemployment of assistants in the British Medical Journal, and various other reports, the report of Collings, and odd bits of information here and there. We cannot quote formal statistics on this particular subject, but we have drawn up definite figures which we think are near enough to it.

2215. *Mr. Watson*: Is it your point, Dr. Russell, that under the National Health Service the assistant has been

exploited by the principal?—*Dr. Russell*: Yes, Sir. I think there are two factors: firstly, that at the present moment assistants are being exploited; and, secondly, that in many cases, in very many cases, a place as a principal is being kept closed for a doctor while he is employed as an assistant. They are two factors which are always in our minds and which obviously overlap; but both, we feel, are relevant.

2216. Is it your second point that an assistant does as much work as the principal and in many cases more?—In our experience that is so.

2217. *Professor Jewkes*: May I go back to this sentence: "Owing to the large surplus of doctors unable to enter practice as principals. . . ." I think *Dr. Saudek* mentioned a figure of 1,546 assistants in 1956. I am looking at the document I suppose you yourself have had—the Ministry of Health Factual Memorandum, page 96. Now, both in England and Wales and in Scotland the number of assistants is falling; the number is less in 1956 than it was in 1952 in both areas. That does not suggest that there is a large surplus of doctors unable to enter practice as principals. It almost seems as if it is becoming easier as we go along.—*Dr. Saudek*: Have you in mind the effect of the Working Party Report which I believe did in 1953 lead to a number of assistants being taken into partnership? The effect of that has come to an end. There has been a slight increase from 1954 to 1956.

2218. And certainly an increase between 1955 and 1956. How do you account for that? Will you just repeat the answer?—What I was saying is that the Working Party Report had a slight effect in increasing the number of principals who took their assistants into partnership because there was a slight financial advantage to be gained; but that effect seems to have spent itself, and I think we are reverting to the position that existed before the Working Party Report.

2219. But there is no question of a piling up of assistants?—No, we have not said that.

Chairman: There has been a piling up of practitioners.

Professor Jewkes: Yes, if you look at the line above, the number of practitioners has increased from 18,164 to

19,951. So the proportion of assistants to principals has been falling steadily. Will you accept that?

Chairman: I think you will have to accept it because it is quite clear it is so.

2220. *Professor Jewkes*: Could you just turn over to the next page, page 98. Appendix T shows the number of assistants who became principals in each of the two years 1955 and 1956. You will see that the number is slightly different in the two years, but there seem to be about 500 assistants becoming principals each year. Now, if there are 1,500 assistants and 500 becoming principals each year, that means on the average an assistant becomes a principal in three years. That seems to me to be a rapid rate of turnover, or would you not agree with that?—I suppose you can draw that conclusion.—*Dr. Russell*: I do not think this Table would suggest that all those assistants are becoming principals as partners in a practice in which they have worked. Some may have endeavoured to have become established by opening a practice, which is a notoriously hazardous procedure.

2221. *Chairman*: I think we have been told, *Dr. Russell*, by other bodies that that is not the common way to open a practice.—But I think approximately 150 doctors a year still do that. 150 are appointed to practice vacancies, which accounts for something like a third, at least a third, of the doctors entering practice.

2222. You think they mainly come from assistantships?—Mainly they do come from assistantships. It would be an extremely rare case where the Medical Services Committee has permitted an appointment of a practitioner to a practice vacancy who has not been previously an assistant. In the same way people opening practices independently very rarely do so from their hospital appointments. In fact they only usually do so after they have tried to become an assistant with a view to partnership.

2223. *Professor Jewkes*: Still, it does mean from these figures that in each year one-third of the assistants cease to hold that status and become principals?—Yes, they become principals in one form or another.

2224. Is not that a fairly rapid turnover? It means that in three years on the average the whole of the body of

the assistants will have been turned over and become principals.—It does not necessarily. Firstly, Sir, of course, that is true if one regards the assistant as a training post. But since the introduction of the Trainee General Practitioners Scheme we feel there is no justification for regarding this assistantship for three years as a training post. It is merely a holding back at that position because there are not sufficient places as principals. A practitioner who does, after his hospital work, twelve months as a trainee general practitioner is then pulled back, on these figures, for three years. But I think the figure is more than that because this Table includes people who enter practice independently. He is held back for three years or more in an assistant's position where he is not training for general practice.

2225. *Sir Hugh Watson*: He is not training for general practice?—He is working as a general practitioner.

2226. *Sir David Hughes Parry*: But he is getting experience, is he not? That is valuable?—Oh, yes, in the same way as a principal, but it is not a training post.

2227. *Sir Hugh Watson*: But if he is working in association with and possibly under the supervision and with the guidance of an experienced practitioner, he is learning his profession and it is useful to him?—We are not denying the value of it. The point we are trying to make is that he has been trained and he has spent his year of traineeship. He is now spending three years or more and, of course, in some cases very much longer, acting as an assistant in a post where he could be used as a principal and where a position for a principal is being kept closed to him.

2228. I know that is your point, but I think you would agree that when a man comes straight out of the Medical School, even if he has been one year as a houseman in a hospital, he has a great deal to learn?—Of course.

2229. And he could very well learn it by being an assistant to an efficient and kindly general practitioner for one, two or even three years?—Yes.

2230. *Professor Jewkes*: May I just clear up one point? Of course, the actual illustrations you have quoted of hardships are very important. I am trying to get the general picture in my mind.

If you look at that Table again, Appendix T, it shows that 40 per cent. of the assistants who have become principals do so at an age under thirty, and 80 per cent. of those assistants who become principals do so at an age under thirty-five. That is a fairly early age at which an assistant should take over in a job as principal—80 per cent. of assistants become principals before the age of thirty-five.—That includes only those who became principals in that year and does not include the figures of the 1,100 who did not become principals. Their ages do not appear in this Table.

2231. *Chairman*: You have got two years there giving near enough the same figures, 80 per cent.—Yes, that is of those who become principals during that year, not the total number of assistants.

2232. *Professor Jewkes*: But is there somewhere—and I think some of your statements rather suggest this—a large number of assistants of advanced age who cannot become principals? Because all these figures suggest a fairly rapid turnover.—*Dr. Segall*: I think what there is no evidence to show is that the 500 assistants that apparently become principals have necessarily been assistants only one, two or three years. Or, to put it another way, there is no evidence to show that the 1,000 in any year who do not become principals will become principals in the next year or the one after.

2233. On the average there is. That is what the statistics mean.—Not necessarily, because other people are coming in.

2234. *Mr. Bonham-Carter*: You are saying that some may go through this assistantship pretty quickly but others may be left there many years?—That is exactly what happens. There are lots of personal factors. Sometimes, for instance, there are doctors' sons coming into partnership, or other extraneous factors. But there is perhaps one general point on which I think we may not have made ourselves quite clear. It is not that we think there is anything wrong in a doctor being a temporary assistant for one, two or three years, although I would like to mention in that context just by the way that it is not only one year for the average doctor in hospital. He usually does more than the minimum one year, then he has got to do two years in the Forces, and very often when he comes

back he goes back to hospital. So that quite likely the minimum period of the typical young doctor before he begins to seek an opening in general practice, even as assistant, is four years qualified. He is not all that raw, and much of the work done in the Army, after all, is of a general practice type.

2235. That brings him to what age?—That would make him about twenty-eight. If he were then going into general practice and knew that as a typical man he had a reasonable chance of becoming a principal in one, two or three years, even that would not be so bad. Some do. But our feeling is, and we cannot prove this statistically—probably only a very thorough investigation of what has happened to doctors qualifying from 1943 onwards would give a satisfactory all-over picture—but our feeling is that even though 500 may be becoming principals every year there are a good percentage of that other 1,000 who never become principals; who leave, in fact, having tried to get into general practice, and return to the hospital service. They seek openings in Public Health. We believe that quite a number go overseas. But, after all, one only has to read the letters in the journals week after week. They may be individual experiences but I think one can say quite definitely that there are symptoms of a general unsatisfactory position. Neither can one really take it out of context with the position in the hospital service. The evidence is that the difficulties of the young doctor in the hospital service are more obvious. If things were more easy in general practice, then the registrars and ex-registrars would come into general practice. In fact, the situation that we are describing reinforces the case for the younger doctor in hospitals and vice versa.

2236. *Sir David Hughes Parry*: You mentioned the hospital. Can we move forward to the hospital medical staff, that is on page 429 of your later memorandum? You deal with that under Section III. What you suggest there is a possible scheme for graded career posts in the hospital service. What alterations from the present position do you contemplate? You have a grade of specialist, senior specialist and consultant; is that right?—Yes. I think to some extent it is a question of terminology. As you are no doubt aware, there has been a good deal of talk about the appointment of

junior consultants, and then other people have started arguing against that because of the concept of the junior consultant—the sub-consultant grade. It is just a question of words, we believe, and perhaps it would be better thought of if what is now being considered as a possible junior consultant were termed specialist and the foremost consultant termed the senior specialist; for the most eminent people in the field reserve the term consultant, which I think is not so appropriate for present day hospital specialist care.

2237. Then you suggest that certain of these posts should be posts of special responsibility and awards made in respect of those?—Yes. If that were done it is quite possible that they would coincide with the term consultant.

2238. *Professor Jewkes*: You do not suggest a salary for consultants?

Chairman: You stop at the senior specialist?—Yes.—*Dr. Saudek*: We visualise them in a part-time capacity.

2239. You regard the consultants as men mostly after retirement?—Yes.

2240. And you propose that a man should be either whole-time or not more than 6/11ths to 7/11ths, part-time?—You want to get rid altogether of the 8/11th and 9/11ths part-timers?—*Dr. Segall*: Yes.

2241. Do you know whether that would be at all acceptable to any or all of the specialists and senior specialists?—*Dr. Russell*: It depends on the appointment.

2242. *Mr. Watson*: The scale of salaries, you suggest, might be in accordance with responsibility?—*Dr. Saudek*: We have said that, yes.

2243. *Chairman*: All the figures you give are identical in that they are based on what you think you ought to start at?—Yes.

2244. Have you any idea how much in total that would add to the present cost of the service, or have you not calculated it?—We have not calculated that.—*Dr. Russell*: Not in the hospital field.

2245. *Mr. Bonham-Carter*: I am not quite happy yet about the second part of that sentence which we were exploring just now, that is, the excess of potential assistants. You remember that you talk about the "surplus of doctors unable to enter practice as principals, an

excess of potential assistants is available". Where are these potential assistants?—*Dr. Saudek*: They are the people who have done their hospital posts and are trying to get into general practice.

2246. Where are they now—in hospital still?—They may be in hospital, they may be in the Services, they may be trainee practitioners or they may be—and there will be a good many of these—just locums doing casual work because they are unable to get any regular assistantship.

2247. So you are saying there is a substantial number who are doing casual work or presumably doing nothing at all?—Yes.

2248. Have we any evidence of that?—Well, we have some evidence about doctors actually unemployed; that comes from replies to questions from Dr. Donald Johnson in the House of Commons in 1956.

2249. *Sir David Hughes Parry*: How many were there—a figure of about 50?—A greater number were reported by Dr. Potter—85 actually unemployed at one particular moment, at the time of answering the questionnaire, which suggests that if you were to take that over the course of a year or more they might have repeated short periods of unemployment?—*Dr. Hilditch*: Can I put in a little point about unemployment? I think it depends very much on how you define the expression and how you carry out your investigation. Dr. Potter simply sent a little form, I think to about 1,000 people, and he said: "Are you unemployed at present"; he did that in about April.

2250. May I ask what people were these; were they fairly newly qualified?—He just sent them to people who were on the books of the B.M.A. as looking for alternative employment. They were not necessarily formerly assistants.

2251. *Chairman*: It was not a random choice from the whole of the B.M.A. list?—No. Generally speaking, these would be unestablished people.

2252. *Professor Jewkes*: They were odd people who wanted to change their jobs or had not got jobs?—Yes. As far as I remember his figures, he got about 400 replies of which 80 in each of his samples said, "I am unemployed". As I say, he did that in

about April which is not the worst month of the year for unemployment. We think if he had done it in December he would have got a very much higher figure and if he had done it in the holiday months he would have got a very much lower figure. In part of our questionnaire we asked it in a different way: we said, "How long have you been unemployed in the last year?", and out of our 111 usable replies 45 of them had been unemployed for some period of time, and the average time of those 45 was 8 weeks in the year.

2253. *Sir David Hughes Parry*: There is one point on the hospital medical staff. In your memorandum you draw attention to the fact that there is a deduction from salary in respect of board and lodging of those who work in the hospitals. I find it a little difficult to see the force of that particular complaint, because if you are at a University with residence provided for you, then a certain amount is deducted from your remuneration. I think at every other place, almost, there is some recognition of that fact, and I cannot quite see what the complaint is, or why there should be a complaint.—*Dr. Russell*: Firstly, the question of income tax rebate, as we point out, and secondly, in hospitals, I think, it is largely a condition of employment to reside in the hospital.

2254. It is a condition of employment at a University that you should reside there.—*Dr. Hilditch*: The hospital accommodation is usually a single room and that is no use at all to people who have got dependants—wives and families. They have got to keep two homes going.

2255. *Mr. Watson*: Who are you talking about?—I am talking about the average junior hospital medical officer. A very large proportion have got wives and families and under the present system they have got to keep two homes going; and they have got this very large deduction which is a condition of employment on which they get no tax rebate.

2256. *Chairman*: A very large deduction?—It is a very large proportion of their income—approaching a third.

2257. *Sir David Hughes Parry*: I thought the figure was about £150 and the total remuneration would be in the nature of £800 to £1,000; is that right?

—*Dr. Russell*: £500 to £600, I think, is the junior houseman's salary.

2258. *Professor Jewkes*: What age are these people? Can you give us some idea?—*Dr. Hilditch*: We have got no formal statistics, but we do know a lot of them are in the late 20's. If you add up the time spent in hospital, doing National Service, it checks. *Dr. Segall*: There is the other background point, if you like, and that is that before the inception of the National Health Service house officers were not charged for residence. Before the National Health Service came in we read about increases in remuneration for house officers and other junior grades and the young doctors thought, "Oh, that's good. That is a fair salary at last." But when they got their fair salary they found that a good deal of that increase was in fact deducted for residence.

2259. *Chairman*: Not the whole of it?—I think probably not the whole of it but I do not think there was very much left. *Dr. Saudek*: I do not think they were very much better off. *Dr. Segall*: I was a house officer at the time when the National Health Service came in and if I remember correctly the actual amount one had at the end of the month was very little.

2260. *Sir David Hughes Parry*: What was the amount of the salary before the National Health Service for the house officer?—It varied. I think it was about £250 to £300, up to £350.

2261. *Chairman*: It would vary a good deal?—It was very variable. *Dr. Hilditch*: I think it is fair to say that some of them, particularly the teaching hospitals, paid about £70 a year, and you could judge the desirability of a hospital post as it was in inverse ratio to the salary paid.

2262. That is what you bring out, I think, although you do not deal very much with it.—We are dealing with the present.

2263. As to whether there should be an inverse ratio because of the other advantages received from having access to the teachers.—We did not bother with that.

2264. That is another point, of course. On your proposals about the Senior Specialists as you call them, you have not got any members in those categories?—*Dr. Segall*: No.

Chairman: In that case we will not talk about that.

2265. *Sir David Hughes Parry*: Now may we turn to page 424 and deal with your remuneration proposals. The first interesting suggestion you make is as to a basic expense payment. You did refer to that in one of the earlier documents, if I remember rightly. The figure that you give on page 424 is: "We propose a basic expense payment of £250".—Yes.

2266. But earlier on in the first document you had a figure of £750 if I remember rightly?—Yes.

2267. Why this difference?—We prepared and submitted our first written evidence before we had the memorandum from the Commission. We therefore just dealt with it in a general way from the point of view of general principles.

2268. *Chairman*: But you mention the specific amount of £750.—Well, the idea was an expense payment to cover expenses but—I will be quite honest about it—we did not think it up to us to make very specific proposals because we were not aware that is what the Commission would want from us. When subsequently we received the memorandum from you in which you asked for specific proposals, we thought it was up to us to look at it as carefully as we could, to look at all the details. So we thought £750 as a non-capitation payment would probably be correct as the maximum; so we are sticking to the figure £750 in that sense. And we have divided it up now, in the later detailed proposals, as £250 for the basic expense payment and £500 for increments over the 20 years period.

2269. I think in your earlier paper you did go on to something additional. Page 398, the paragraph headed "Practice Expenses" gives the £750; and the next one refers to increments in respect of age and length of service.—But we did not specify an amount.

2270. No. I did not understand, I must admit, that they were meant to be included in the £750.—We did not think deeply on that because we were concerned with general principles. If I can put it the other way: if we had had the Commission's memorandum before we prepared our first memorandum we would of course have approached it from

the point of view of getting the details first.

2271. At any rate, you would wish us to pay attention to the figures on the second memorandum rather than the first?—Yes, so far as the figures are concerned, but of course the principle is the same in both cases.

2272. *Sir David Hughes Parry*: We appreciate your frankness in saying that you have shifted your position a little in this respect.—So far as interpretation of details, yes.

2273. "We propose a basic expense payment of £250". Do you wish to add anything to that, because that is an interesting proposal? You are contemplating £250 for the man who sets up his plate, for all who are in the National Health Service; that is the general position?—*Dr. Saudek*: With the exceptions provided for.

2274. *Chairman*: This is "to diminish"—as you put it—"to some extent the excessive competition for 'units'"—I suppose we are "units"—"resulting from the capitation fee method of remuneration". But when the British Medical Association were here they said quite definitely that the test of ability of a doctor was the number of patients he had on the books—I am paraphrasing what they said. Do you agree with that definition?—No. *Dr. Russell*: It is only a test of his ability to attract that number of patients; it is not a test of his ability in any other way. It is just arguing round in a circle. I would refer to a simple example of a practice. I know well in my own area, which has had five incumbents, if I may put it that way, over a period of 15 years owing to various circumstances. And the practice has remained static within about 10 per cent. It would be a most remarkable thing if all those practitioners had exactly the same ability.

2275. *Professor Jewkes*: Is there nothing in this idea that a doctor may be popular because he is efficient and conscientious?—Of course. I am not trying to suggest that it is not a factor at all, but merely denying that it is the sole factor. It is merely one factor which I would say in our experience is not the most important factor.

2276. *Chairman*: What you are saying is that whatever might be the net pay-

ment in respect of heads—"units"—the gross payment which includes an element for expenses should not be entirely related to that, because some expenses are standard?—That would be so. Obviously one could argue that one should pay a doctor more because he is looking after more patients; that is a perfectly logical argument. But that would not be because he was more able, but because he was doing more work. But the expenses do not increase pro rata with the size of list; whereas the present method of remuneration is based largely on the principle that that is the case.

Chairman: I think the Commission have got the point. On the precise measure of it, whether it should be £250, for instance, or not, or some other figure, I do not know whether you have any particular reasoning as to that figure?

2277. *Sir David Hughes Parry*: I was going to ask that, Sir. Why did you fix £250? Obviously it is after deliberation.—It is after very great deliberation. I suppose it is a compound of what we consider practicable and reasonable, and also of what we know. It represents what we consider the basic essential expenses which no practice even of one patient can avoid, and at the same time is not, we think, a figure which is excessive, as I think was our first figure of £750, which would cover a large number of expenses but would not be realistic for a small practice.

2278. *Chairman*: Does the loading from 501 to 1,500 patients at the present time, within that range, have something of the same effect?—It does, Sir, for practices above 1,500, more than for those below 1,500, because it really becomes a basic salary only for people with lists above 1,500.

2279. *Sir David Hughes Parry*: Now may we move on to increments? You suggest an annual increment of £25 per annum for 20 years. What is the object exactly of the increment?—Twofold, I would say. Firstly, as we have said here, for seniority, experience and the usual factors which apply in any incremental scale. And secondly, again in order to reduce what we have termed "head-hunting" which we do not think is something we should encourage on the whole in general practice. We feel that we can achieve better results in general practice if the remuneration is less tied

solely to the ability to attract patients which encourages this type of "head-hunting".

2280. And you think that it is experience and length of service that ought to count? You do not mention merit or anything of that nature at all?—We did consider this, and we are not opposed to merit awards, but we could not see any means of achieving this. We could not see any means of assessing merit in general practice and therefore we have been unable to make any recommendations. I myself would think that perhaps the only people who could assess merit of a general practitioner in practice would be the medical staff of a hospital in the district. I am sure the whole profession would object to that method in the same way as we would object to judging the consultants.

2281. You came to the conclusion that the only thing that was practicable was to reward experience; is that right?—Yes.

2282. *Chairman*: You still do not think that patients in total are any judge—or at any rate, very much of a judge—in assessing the relative merits of different doctors?—They are not a judge in the same way as colleagues would be, in the sense of medical ability.

2283. One of the reasons in your earlier memorandum, in the first part, page 398 under the heading III, why you want increments was to "obviate the necessity for a practitioner continually to enlarge his list over the years in order to meet increasing personal and family commitments". Most people who want to meet increasing personal and family commitments out of professional remuneration have to save up for them. —I would have thought that by and large the figures in the appendices show that most people in either salaried or Government employ do have increments.

2284. *Sir Hugh Watson*: We are talking at the moment about professional people—doctors—whose normal remuneration is by way of fee, and the present system of payment of doctors under the National Health Service was the nearest that anybody could arrive at as a substitution for the payment of fees. Now, these professional people earn their living by fees and as they go on through their professional life they earn as many fees as they can and they take the rough

with the smooth, do they not? And they have to save up. It seems to me that when you begin to talk of a salary scale and increments, then you have arrived at the very antithesis of a professional arrangement at all. What would you say to that?—I think the hospital doctors have got perfectly good professional arrangements although they are on purely salary scales. Our suggestions are what we consider a practical middle course between a salaried service with the disadvantages that would bring and the present purely fee service, as you term it, and the disadvantages which that at present entails.

2285. *Mr. Watson*: Surely the doctor in hospital cannot plead for an increase in his salary because of his family commitments?—No, Sir. But then, this sentence should, in fairness, be taken in context. The hospital doctor does not increase his number of appointments as he grows older in order to increase his income, whereas many general practitioners are forced to take on more work than they would otherwise wish to because the only way to increase their income is by increasing the number of patients.

2286. *Chairman*: Where do they get the extra work from? They are taking it from the other doctors?—From their colleagues in the area.

2287. Who are also presumably trying to increase?—For example, in a B.M.A. Report by Stephen Hadfield I think it was quoted that 25 per cent. of doctors would prefer to have lists of 2,000 to 2,500, but kept more patients purely because that was the only way they could meet their commitments and earn a living.

2288. *Mr. Watson*: They want the smaller list with the same income?—They want a smaller list with an adequate income.

2289. The older they got the more income they wanted?—I do not know, Sir, about the age. He did not quote any age figures in his report.

2290. *Professor Jewkes*: I would like to press this a little further. Why should you pay a doctor more just because he is older?—Because of his experience.

2291. I would have thought that is not an answer that would have appealed to your Association.—*Dr. Russell*: All

the more merit in it then.—*Dr. Sauderk*: It is done in the Civil Service, it is done in the Public Health Service.

2292. *Profesor Jewkes*: You think we can roughly assume, although there will be exceptions, that the older the doctor the more experienced, the more competent, he is? You feel this would be a good way of trying to reward what you regard as the more competent doctors?—*Sir David Hughes Parry*: Up to 20 years.—*Dr. Hilditch*: In a way, it balances: a good doctor, as he gets older, becomes more competent; a poor doctor probably becomes less competent.

2293. *Profesor Jewkes*: But you are going to reward him, are you not?—Yes. With all its failings we think it is a better method than simply allowing him to extend his list.—*Dr. Segall*: We have not suggested any sort of merit award for two reasons. Firstly, because we think in practice it would be difficult. The consultant merit award system has been subject to a good deal of criticism and I think that a merit award system in general practice would be even more difficult. But if it were possible we would not necessarily say that we would be opposed to it. What we would say is that a merit award should be super-imposed upon a basic expense factor and a length of service factor, as we have suggested. In the same way as with the hospital consultants, the merit award system exists but so does the increment system for everybody. In other words, we have only gone as far as suggesting what we would say is a basic principle, and that does not imply that if a merit award system be super-imposed on top of it that we would oppose it.

2294. *Mr. Watson*: Do not your proposals mean leave out the word "merit" and substitute the words "age and experience"? Doctors should be given age and experience awards within a global salary?—We have taken what we think is one step away from the present system of capitation fee. We have not presumed to take two steps. But if that step were taken, that does not mean to say that either in addition now or in addition in so many years time the second step could not be taken. We are not opposed to that; we just do not think it is for us to go that far.

2295. *Chairman*: You are proposing, in fact, two steps?—Well, yes.

2296. Two at least. Are you really tending towards a salaried service entirely, instead of a capitation fee service?—No, Sir; because purely on objective grounds we do not think that a salary method is possible or advisable so long as doctors are working from their own premises. But, as we have said in our proposals, so far as health centre practice is concerned, we are in agreement with the views which were put forward in the Government White Paper on the National Health Service at its inception that health centre practice is different and should be remunerated along salary or sessional lines.

2297. *Mr. Bonham-Carter*: Your reservations about salary have nothing to do with doctors in a health centre?—No. Well, indirectly, perhaps. So long as the doctor is working from his own premises we do not think that a salary/session method is either practical or advisable.

2298. Practical, I accept. That is mainly because of the tax question?—All sorts of questions affect it. The doctor owns the premises, he owns the equipment; he has got to meet those expenses and therefore the whole basis of it is that of a private practitioner.—*Dr. Russell*: In addition, in a health centre where perhaps 6 or 8 doctors work as a group, the patient has as much freedom of choice as in an area where there are 6 or 8 doctors.

2299. *Chairman*: You are in fact against a salaried service except in health centres, but you want to introduce a substantial element of salary into the system?—It is not that we want to introduce a salary element. The motive is to reduce "head-hunting", as we have termed it, and therefore the method is to introduce some salary elements.

2300. You propose to introduce some elements of salary into remuneration?—Yes.

2301. I think you say, *Dr. Segall*, you aim at evening up the partnership takings, where there are partnerships between the presumably younger new partner and the senior partners?—*Dr. Segall*: Yes.

2302. Yet at the same time you propose exactly the opposite by paying the senior ones more for experience and age?—*Dr. Sauderk*: I think we did not take the two factors in opposition. We are merely trying to ensure the

junior partner gets a fair share of the profits in relation to the proportion of work that he is doing. We recognise that he can hardly expect an equal share when he first joins the partnership. We think he should get at least one-third, and then within five years he should be entitled to an equal share.

2303. Apart from age increments, or including them?—(Those, of course, will be pooled with the partnership profits.

2304. So that the man who has not got 20 years' experience will still get the benefit of it at the expense of the man who has? I am just asking the question; I am not sure what you meant?—Would you repeat it, please?

2305. You said the age and responsibility payment would be pooled for the partnership profits and would be shared in accordance with the partnership arrangements that you propose?—I should imagine normally, yes. It would be a matter of arrangement between the partners.

2306. *Sir Hugh Watson*: That means, if I am 50 and you are 30 and I take you into partnership I get this increment that you are talking about, but when you have been my partner for five years we split the profits of the partnership 50:50 and you put half my age increment in your pocket?—*Dr. Segall*: I do not think there would be anything against increments being treated differently from the rest of the partnership profits. The usual procedure is that doctors in partnership pool all the takings and then divide them out on a percentage basis. But I think it quite likely so far as increments are concerned, being such a personal factor, it might be better that they should be treated separately. But we doubt somehow whether that could be decided other than by individual partnerships.

2307. We have got the door open a crack. We have got the senior partner entitled to a responsibility benefit. Would you not agree that for quite a considerable time the senior partner ought to get a better crack of the whip than the junior merely because he is more experienced and senior?—I do not think we have ever said . . .

2308. You want parity after five years?—It is a question of how long.

2309. *Chairman*: But you do want parity after five years, do you not?—

As far as the present situation is concerned I should think that would be reasonable.

2310. I think whether it is reasonable is another matter, but that is what you are proposing?—Yes.

2311. *Professor Jewkes*: There is one expression you use several times and I should like you to amplify it for us: "head-hunting". I take it you are not just referring to the ordinary custom of a doctor trying to increase his list? What else is involved in "head-hunting"?—*Dr. Russell*: That is what we refer to. But it involves competition between doctors in the same area. In other words, there is difficulty in co-operating with fellow practitioners because of this competition.

2312. What form does the competition take?—*Dr. Saudek*: It involves giving people certificates if they want a day off and it is a little doubtful whether they deserve one, or possibly giving them a nice pink flavoured medicine or tablets if they want it, or vitamins, whether or not they need them; or a letter to a hospital when a letter is not necessary. It does involve a lot of consideration of what the patient wants and trying to please the patient.

2313. *Mr. McIntosh*: Would you say that is very widespread?

Chairman: The certificate part, for instance?

Mr. McIntosh: It is the certificate I am thinking of.—Yes, I would say the statistics bear that out.—*Dr. Russell*: The figures of the Ministry of Pensions and National Insurance do suggest that it is not insignificant. It is always a very difficult thing to assess this because the main point is that it is very difficult to be objective about the treatment of a patient; it is very difficult to be entirely objective on the capitation fee system.

2314. *Chairman*: You are referring to the letter that was in, I think, the *Manchester Guardian*?—A day or two ago—on Monday. That letter is obviously open to misinterpretation; but the actual figures do suggest that there is an element of doubt in certification and we would say that is probably due to the capitation fee.

2315. *Sir David Hughes Parry*: There are two possibilities: that there is in

fact very little of it which is obvious, but there is in the minds of doctors much fear that there is a lot of it?—Yes, Sir, that is true. As I said, it is very difficult to feel that one is being objective, however hard one tries. One is never certain in one's own conscience that one is being absolutely fair to all the parties concerned.

2316. *Sir Hugh Watson*: You mean when you are asked for a certificate?—Yes; and for specific prescriptions.

2317. *Chairman*: There is always a borderline case?—Yes.

2318. *Sir David Hughes Parry*: You are not condemning competition as such? What you are condemning is certain unethical methods to make the competition keener?—We are not by any means. We would encourage competition in the medical sense. We are obviously in favour of that, but we do not think this is a type of competition which is good practice. Competition within the medical profession, of course, we are in favour of.

2319. *Sir Hugh Watson*: This could have happened even before the National Health Service, could it not?—Yes.

2320. *Chairman*: And do you say that it did?—*Dr. Segall*: The fact that the whole population was not covered makes a tremendous difference. The vast majority of people are now registered with a general practitioner and the bulk of the average general practice work is National Health Service, and we think that makes a tremendous difference.

2321. *Mr. Watson*: There is a slight difference. Before the Health Service the patient had free choice of a doctor; now he must go through certain motions to change his doctor?—There is that difference.

2322. Is not that a very big restriction?—We think it is an incorrect restriction. We think it is unfair both to the doctors who are trying to build up practices and, in a sense, to the patients.

2323. Would not that encourage "head-hunting"? If all these malpractices are going on in the Health Service and the patient was free to choose his doctor without any restriction at all, would not that increase "head-hunting"?—I doubt it. I think the position at present is that the

person who wants, for any reason, to change his doctor, temporarily or permanently or maybe for a particular condition, feels somehow that he or she cannot do that. Whereas the person who, shall we say, is either unduly medically-minded or, if it is possible, even out to get some benefit from the Health Service—at least, some imaginary benefit—would not be deterred by the regulation. In other words, the person who should perhaps be restricted is not restricted by the present regulation tonight, whereas the people who are reasonable are the ones who are restricted.

2324. *Chairman*: You would at least limit in quantity, Dr. Segall, I gather, the possibility of head-hunting by the signing of certificates or anything like that by reducing the maximum number of people on a list to 2,000 patients per doctor?—I think that is one way. The other way is by introducing part of the remuneration by non-capitation methods—basic expenses and increments; that in itself would reduce the relative importance of the "unit".

2325. It seems to me that with the number of patients at about a 2,000 level many of your proposals about increments and expense payments are not going to make any less the difficulty you say comes from other sources under the capitation fee method. Is the man with 2,000 patients just going to get all this as an extra?—No; I think we envisaged that if one takes the practitioner who at present has 3,500 patients—assuming, of course, the same value of money throughout—and who has been in the National Health Service since the beginning, he would in ten years' time receive the same income for 2,000 patients, so that his relative position has not changed.

2326. And the man with 2,000 patients now, what would be his position in ten years' time?—He would be much better off.

2327. *Sir David Hughes Parry*: I wonder if we could get at that main issue of the reduction. This is your main proposal, the reduction of the list from 3,500 to 2,000?—Yes.

2328. Are you contemplating a maximum number or an average?—A maximum of 2,000.

2329. Why do you want to reduce the numbers? I would like to know the reasons why you recommend us to say that there should be this maximum?—Because we believe it is quite impossible to practise medicine as it should be practised and can be practised today with 3,500 patients.

Chairman: You consider 2,000 is the maximum that really can be managed?

2330. *Sir David Hughes Parry:* I would put it the other way: what are your reasons for fixing it at 2,000?—We have quoted various opinions. One has to fix upon an exact number, but the figures there in the evidence are from various sources, from suggestions, from investigations, and partly from other countries, and we think that 2,000 would be something to aim at. But that does not mean to say that is the optimum; quite possibly it would be less. I should be very surprised if it is more.

2331. There is some implication, is there not, that those with 3,500 on their list now are not really rendering the best service in the National Health Service?—The best possible service. It is a question really, I think, of the methods and the approach of general practice today being essentially similar to what they have been in the past. Good as they were when the National Health Insurance was introduced after the First World War, they are unsatisfactory by modern standards.

2332. And yet, coming back to the Chairman's proposal, when you are reducing the numbers you do not want to reduce the remuneration of those who have been "head-hunting" and whom you are condemning?—Because we are not condemning them. Everybody has to try to get to the top of his particular line or do the best that he can. What we think is quite wrong is the numbers that were thought about when the National Health Service was first introduced as to what should be the number of patients per practitioner.

2333. Do you think that if in ten years or in five or seven years the numbers are reduced to, say, 2,500 to 3,000, there are sufficient doctors in the country to meet the demand?—I should think so; with a redistribution of patients, certainly.

2334. *Professor Jewkes:* You mention 2,000 as the principle you are after. 2,000 multiplied by the number of doctors would still leave some people in England without a doctor. But beyond that, of course, would you not accept the idea that in some places there would have to be much less than 2,000?—Oh, yes.

2335. Therefore, if there is no doctor with more than 2,000 and some of them have less than 2,000, clearly there would be some people in England who would not have a doctor at all?—*Dr. Russell:* It is over a period of ten years that we are contemplating this, and perhaps that is true. This is something that we have not prepared specifically for the Commission, the figure of 2,000; it is something which has been our policy for some time, before the Willink Committee produced its Report based on the fact that there would be no increase in the number of doctors. This figure may have to be amended above 2,000, but it will not be amended because it is better to have more than 2,000 patients but because there are not enough doctors.

2336. You would like to see an increase in the number of doctors?—*Dr. Segall:* If necessary. Relatively we are not an over-doctored country.

2337. *Sir David Hughes Parry:* But for the next five years or the next seven years you cannot increase the number?—We have suggested doing it by stages.

Sir David Hughes Parry: The numbers of doctors are fixed.

2338. *Mr. Gunlake:* You do suggest in the first stage there should be an immediate reduction in the list from 3,500 to 3,000. First of all, it seems to me dubious whether there would be the number of doctors to cope. I would also like to ask, how does a doctor with a list of 3,500 get rid of 500?—*Dr. Russell:* He does not. In my experience the average turnover is about 15 per cent. per year.

2339. *Chairman:* Are you in a large town?—Yes, I am in a suburb of London.

2340. There is probably a bigger turnover there than in some of the more country type of districts?—Yes. I think the national average is something about 10 per cent. That means that a doctor with 3,500 patients would take

sixteen months, if he did not accept new patients, to bring his list down to 3,000. That is in fact what we did in 1953 when the lists were brought down from 4,000 to 3,500. Those doctors who did not take partners were given a year and then another period of a few months, and all they needed to do was not to accept new patients except in marginal cases.

2341. *Mr. Gunlake*: When you suggest an immediate reduction by 500, you do not mean immediate?—Over a period of twelve months or eighteen months.

2342. *Chairman*: I think somewhere. Doctor, you suggest that this reduction of the permitted maximum number of patients should not provide a greater freedom for more outside private work, do you not?—I think we said not to limit the freedom to do outside work except where there are substantial other commitments such as long hospital sessions.—*Dr. Segall*: I think our point was that if a person has a large amount of outside work then the maximum should be less, and that again, I think, was a principle stated in the 1944 National Health Service White Paper.

2343. *Professor Jewkes*: You mean every doctor will have to state how many private patients he has, and then his official list would be adjusted?—Yes, I think it only applies to where a very substantial amount of the work would be outside work.

2344. But in order to find where the work was substantial you would have to investigate every case. Every doctor would have to report the amount of private practice he had?—*Dr. Russell*: At the moment every doctor has to report to the Medical Practices Committee in general terms the approximate number of half days per week he does of outside work. That is already being done; each doctor reports annually to the Medical Practices Committee.

2345. On the quantity of his private practice?—Yes.

2346. *Mr. Watson*: Dr. Russell, if a doctor had 2,000 patients on his list, which you feel is a level which would ensure his patients good medical care and attention, what limit would be put on his private practice?—That is something we have not considered in detail, because I do not think that we could quote a figure in financial terms. We state specifically that if a substan-

tial portion of his time is spent in outside commitments—a doctor spending, say, to take an extreme example, seven half days per week on outside work, private practice—then one would consider that he was not in a position to be able to devote the same standard of attention to 2,000 patients under the Health Service.

2347. Under these proposals before us you visualise that at a certain stage a doctor who had 3,500 on his list would receive the same salary when he dropped down to 2,000. Would you then suggest he should have complete freedom to deal with private patients? He would have lost 1,500 off his list, and he would suffer no reduction in his salary. Would you suggest that he should still go on with private patients without control?—I do not think we could place the control on the number of his private patients or the amount of income. One can only place that control on the time he spends outside his practice.

2348. Your basic case in this matter is that a general practitioner cannot competently attend to more than 2,000 persons on his list?—*Dr. Segall*: I do not think it is a question of competence. It is a question really whether the general practitioner service should be elevated to the position of raising the positive health standard as well as the care of the individual when he is ill. We have in mind that the general practitioner service should be up-graded and should be able to provide positive help for the patients and detailed care and attention.

2349. *Chairman*: But you are saying that any doctor who includes as part of his job looking after the positive health of a patient cannot deal properly with more than 2,000 patients?—I say, Sir, that we want the best service that is possible in the light of the tremendous advances which have taken place in medicine and the outlook of medicine even in the past ten years; and that is not possible in terms of 3,500 patients.

2350. What I want to get at is if you think that a doctor should be limited to 2,000 patients ought you to allow him to take any remuneration for anything outside in addition?—Oh, yes; except that if it were substantial then there should be a limit, exactly as it was proposed in the 1944 White Paper.

2351. *Sir David Hughes Parry*: I gave you the opportunity at the beginning of

the first question of explaining why you wanted to limit the figure to 2,000. I thought you had made it quite clear that you wanted to improve the quality of the National Health Service by giving more time to the doctor to attend to the patients on his list. Now it does seem to follow from that, does it not, that if he is relieved of the burden of some of his National Health Service work he ought not to assume a burden outside it by taking hospital appointments and so on? —He should not use that extra time for those purposes.

2352. *Professor Jewkes*: I was interested to learn that you do already report to the Medical Practices Committee how much outside work you engage in.—*Dr. Russell*: That is true.

2353. What form does that take? Do you explain how many private patients you have?—No, Sir. The purpose, if I may explain, of this enquiry is simply to enable the Medical Practices Committee to decide in borderline cases the designation of an area; in other words, to decide whether more doctors are required. They say they require an estimate of whether many of the doctors in the area spend a substantial proportion of their time on other commitments. The actual enquiry, as far as I remember the last one I received, was merely one or two questions to say how many hours per week approximately were spent on medical services outside the National Health practice and what form they take; hospital appointments, private practice, Medical Boards, and so on.

2354. This is sent to the local Medical Committee?—No; in England and Wales it is sent to the Medical Practices Committee.

2355. *Chairman*: For the purpose of designating areas?—Yes. It is not used, as far as I know, for any other purpose.

2356. Does that mean that they would have an idea of what proportion of a doctor's time is taken up with outside work?—Yes. It is not a condition of service to reply to this question, but I gather doctors mostly do.

2357. *Professor Jewkes*: Is it sent fairly regularly to you? You mentioned you have had this more than once?—I can recall having two in three or four years.

2358. *Chairman*: On this question of the 2,000 patients, you agree, I think,

that there are many different areas, and that if 2,000 is the maximum in the most favourable concentrated area, then the number that can be done with the same efficiency in scattered areas will be much less?—It would vary in individual circumstances in a particular area. We have taken, I think, an average area with average morbidity.

2359. Your figure is a maximum?—Yes, a maximum figure for an average area.

2360. But in an area that is more concentrated than average you would still have that as the maximum?—Yes.

2361. Then would you also say from your own knowledge that the ability of doctors to get through jobs quickly and thoroughly varies from one doctor to another? I should have thought it was bound to.—Of course.

2362. Again you are basing this on a maximum figure, so that in total the average would be a lot less, as Professor Jewkes suggested earlier. We have not tried to see how much. Have you any idea, if the maximum is 2,000, what would be the average number of patients, assuming that you want everybody to have the same opportunity?—We should hope that as it works out at the end, and there are obviously going to be three stages, a majority of practices would be around 2,000 or just below, within a few hundred of the maximum of 2,000.

2363. You would not expect that any practices, for instance, in country districts or any practice of rather slow doctors with lists at present under 2,000 would come up to 2,000 if they had to do more National Health work? You would not expect them to be able to handle more patients than they do now?—I am speaking of a majority of practices, which after all are largely in urban areas in this country.

2364. Have you made any estimate at all of the cost of your proposals to the country? You said you had not estimated costs as regards the hospital salaries. I rather thought you probably had on the G.P. side.—Not in specific terms, but we did in round figures assess the Central Pool at £60 million at the moment; this would be somewhere between a 20 and 25 per cent. increase in costs.

2365. *Professor Jewkes*: In fact, it is about the increase that the medical profession is demanding?—We thought it was not a wild goose idea, if I may put it that way.

2366. You would not intend to give the man with the top list anything at the moment. He would just do less work for the same money. But the other people would get more money, the people with the smaller lists?—As *Dr. Segall* said, we have left out merit awards which might go on top of this because we thought that would be the only practical way we could see of increasing the remuneration of the man with the top list now. We feel all the way through that it is far more important to look at the average practitioner; the basis of the remuneration is far more important over the complete range of general practitioners, than it would be to look at a handful of 3 or 5 per cent. We feel, both from the point of view of recruitment and the standard of service that that is more important.

2367. Since we have got on to that, could we just see what the scheme would imply? First of all, the doctors with the largest lists would have smaller lists and the same income. All the other people would get larger incomes, but the average list would tend to go down to 2,000, that is the ideal; the nearer you get to that the better. Under those conditions, as you explain on page 425 a man with a list of 2,000 would have an income of £3,925?—*Dr. Saudek*: At the end of ten years.

2368. At the end of your scheme. At the moment a man with a list of 2,000 gets something like £2,375, so the average payment of doctors would go up from £2,375 to £3,925. Is that the sort of increase you had in mind?—*Dr. Russell*: That is the doctor who would receive the maximum benefit at the end of ten years from this scheme. That is not the average doctor.

2369. I am only using that as a basis to get an idea of the situation once the scheme has been introduced. You bring the position as near as you can to 2,000 patients per doctor, then they would receive on the average something like £3,925?—*Dr. Segall*: With twenty years' seniority; having served in N.H.S. general practice for twenty years. So that, supposing, for example—it

would be most unlikely, but suppose—that somebody joining at that time found himself with the full list but no seniority, he would have £500 less.

2370. *Chairman*: It is not the average. The average over the whole of a doctor's life would obviously be less than at twenty years' seniority, but possibly more than at present. So that it is still within £250 at the most of that top figure that has been mentioned. If you compare what they would get under the present scheme if everybody was reduced to 2,000 maximum, and everybody with 2,000 under your scheme, the comparison is between £2,300 and about £3,700, which is quite an increase. Together with the fact that there would be a good many more doctors, so that not only would each of them be getting more but the total remuneration would be very much greater.—*Dr. Saudek*: That increase would not apply to everybody. There are a good many just above 2,000 now, and they are all going to be within a range of no increase at all up to the maximum.

2371. And a good many below. But they will all get some increase?—They will all get some increase except people with 3,500. As to people above 3,500, they will have a slight reduction of the capitation fee for the extra list.

2372. *Mr. Watson*: Has your Association ever considered the adoption of a central pool of all the fees received from private practice?—We are against the Central Pool scheme.

2373. *Chairman*: Are you?—*Dr. Russell*: There is, of course, a figure deducted from the Central Pool for private practice.

2374. *Mr. Watson*: You are seeking over a period of, say, ten years with twenty years' seniority a salary of approximately £4,000 per annum with a list of 2,000 patients; that is a salary equated to 2,000 patients. I just asked, has your Association ever considered that the amount of money received by a doctor over the £4,000 with 2,000 patients should be allocated to a central pool and not received by him as an individual?—We have never considered that.

2375. So in addition to the £4,000 on your scheme he still would have what income he could get from private patients?—*Dr. Segall*: Not necessarily.

2376. He still can receive from private patients additional moneys?—Some, yes.

2377. *Chairman*: And he can, for instance, do industrial medical work, become a Works Medical Officer, or something like that, as well as having 2,000 patients?—Yes; I think so long as it is limited in extent.

2378. Limited to what? "limited" is rather a vague word.—I do not think we are in a position to say what. But the idea of that limitation of a large amount of outside work came from the Ministry of Health in 1944, and that is really our authority for quoting it.

2379. A doctor with about 3,500 patients who is reduced to 2,000 patients under your theory will feel, do you not think, that he can do a great deal of additional work outside—because there are areas and types of conditions and partnerships which make it possible.—I think that there would quite possibly be people like that.

2380. Will not almost all those doctors feel that if in the past they could cope with the difference between 2,000 and 3,500 patients, they can do a very great deal of very remunerative outside work in place of that?—I think that the average doctor, given the opportunity to practise medicine as he was taught it and as he wants really to practise medicine would do that if there is not the financial pressure. I do think that, together with reducing lists, there are a lot of other things that should be done. If you keep the lists as high as they are, then all the efforts that people are making—and there are efforts within the profession—to raise the standard to that required by today's state of affairs are wasted. In other words, irrespective of ancillary help, irrespective of methods of investigation, the doctor has not got adequate time to give to each individual the best standard of medicine, which we regard as the fundamental point. It is even more fundamental than as to whether a practice is carried out in a Health Centre or some private practice. In general, if medicine is carried out under stress, under speed to get through the patients quickly, that standard of medicine is not as good as it should be; whereas, if a doctor has got time to take details of a patient and look at all aspects of a patient, as one is taught in medical

schools, then the average doctor will make a good job of it.

2381. I think you agree that if the State is being asked to carry out those proposals so that a doctor shall have more time, it should have some right to see that the time is used for that purpose and not for anything else. Would you agree with that?—Yes, Sir, if it is necessary, certainly. I think in fact that there is in theory that possibility today with Regional Medical Officers.

2382. *Sir David Hughes Parry*: You do say now that what counts at the present time with many of these people who have got the 3,500 and upwards is the economic motive: that is right, is it not?—Yes.

2383. They have got 3,500 because they really want to make money out of it?—Yes; that is because it is the accepted thing. Really one can say that the typical traditional methods—there are many exceptions, of course—of N.H.S. general practice today are the same as they were when the N.H.I. was introduced. To quote Collings, for example, which was the first detailed survey of the N.H.S. under general practice, he made the point, in referring to the unsatisfactory standards, that they were not introduced with the National Health Service. When the National Health Insurance was introduced there was a tremendous advance, but if the methods have stayed still for thirty years and medicine has not stayed still for thirty years, then it is not good enough today.

2384. *Mr. Gunlake*: What you are really advocating is, to quote a familiar phrase, in medicine the best should be available to all?—The best that is possible.

2385. Irrespective of cost?—There must be a limit on cost, but I think the main point is a question of time. Ancillary investigations and help are tremendously important, but the most important is really knowing a patient, really taking history, really carrying out an examination, as one is, in fact, taught in medical schools. I can assure you that there are very few medical students who leave hospital and first go into general practice—there are exceptions—who are not profoundly shocked.

2386. *Mr. Watson*: Would you not say that is a very good reason why a doctor with 2,000 on his list should have no private practice?—Well, I do not

think that an absolute embargo is necessary.

2387. *Chairman*: But you are putting an absolute embargo on the number of patients that anybody can deal with?—That exists at present.

2388. Yes; but you are reducing it very much?—Yes, reducing it, but that embargo exists at present as far as N.H.S. is concerned.

2389. Do you know any other country where there is a maximum of 2,000 patients?—I do not think any other country has a National Service organised quite as we have; but, for example, there is the Health Service in New York which we quote on page 428 of our Evidence. I suppose it is a voluntary scheme. 1,500 for a general family practitioner and 800 for a paediatrician practitioner.

2390. "The maximum list for a family internist in the Montefiore Medical Group in New York . . ."—It corresponds really to a large group practice which works for a certain area and in conjunction with that area, but it provides a family practitioner service, the only difference being that they divide their general practitioners up into general general practitioners, as it were, and paediatrician general practitioners.

2391. *Professor Jewkes*: I think I am satisfied now that your scheme would cost about 30 per cent. more. But, of course, it has this peculiarity, that people with large lists would not get any more and people with smaller lists would get more. So what you are inviting us to do, if we accept your scheme, is to put forward a new system by which certain doctors would not get an increase in pay. That would not be very popular, would it?—*Dr. Russell*: There would be a considerable reduction in the number of patients.

2392. *Chairman*: But no increase in pay?—*Dr. Segall*: We say that this is the minimum. If the Commission want to go higher so as to give the 3,500 increases we would be not at all against it.

Chairman: I think some of the other bodies will be glad to hear that.

2393. *Mr. Bonham-Carter*: Have you considered the effect of £25 a year to a man who is paid monthly, or is it quarterly?—Quarterly.

2394. Have you considered the difference it makes in the size of the cheque

after tax has been taken off? I will tell you it is very small indeed.—Yes; except that the man who was in the National Health Service from 1948, and presumably most of those would have the larger practices, would in fact be getting a £250 increase.

2395. The first time you would. The point is, I wonder if you have considered at all that by doing it by such small increases the whole effect is lost?—With regard to the National Health Service it would be. For that very reason we would say that for such a small amount it would have to be retrospective.

2396. *Sir David Hughes Parry*: There is one small matter that I want to raise with you about restrictions on doctors in two ways: by contracts and, presumably, by general practice in the region. I am not quite clear what the position may be under the National Health Service. Do doctors have these restrictive covenants now, as they did before?—Yes.

2397. And presumably the same legal principles would apply to their interpretation and their enforcement as before?—Yes.

2398. In those cases the law took the view that no enforceable covenant was unreasonable, did it not?—Yes.

2399. If the assistant or the partner by entering into the contract thought the restraint under the covenant was unreasonable, he could ignore it, could he not?—*Dr. Hilditch*: It depends on what you mean by unreasonable.

2400. Well, there is a legal standard for it.—I think it is a standard dated long before N.H.S. days. After all, it was reasonable to stop a chap practising within a few miles of you if he could go somewhere else. Nowadays it is very much more difficult to go somewhere else, and it becomes far less reasonable.

2401. You have been condemning the exploitation of the assistant by the principal, have you not? Now there is a possibility that the assistant, if he were to set up his plate near where he had been practising, would be exploiting the principal, is there not?—Yes.

2402. The principal has an interest in the area?—Yes; it is a matter of degree. After all, even if an assistant does set up close to a principal, it is very unlikely that he is going to do the

principal out of his living. He may take a certain number of patients off him, but it works the other way much more strongly, if the assistant is prevented from practising in that area, it may condemn him to quite a long period of being an assistant or not being able to establish himself.

2403. You do not trust to a judge that he will be reasonable?—It is the interpretation of the application. It does not come to the law in the majority of cases. Very few assistants would risk setting up and, as it were, putting themselves into a test case.—*Dr. Russell*: I think, Sir, it has become a little bit wider, too, from the point of view that nowadays more assistants do more assistantships than previously; and in addition, of course, there is the factor of the Medical Practices Committee. When a practitioner wants to set up on his own he is in fact limited to those areas which are designated. Therefore, a large part of the country is lost to him. If in addition he must have a trainee assistantship, and perhaps two or three assistantships in different parts of the country, and in each of those areas restrictive covenants apply, then it may have a very serious effect on his future living for the rest of his professional life if he signs restrictive covenants with various principals.

2404. *Chairman*: For the rest of his professional life?—It very often applies for a period of five or ten years. If one is, perhaps, in one's thirties and one cannot start a practice in a large number of areas or a number of areas for five to ten years, it does affect one's professional life.

2405. *Sir David Hughes Parry*: Have you considered the facts and the decision in the most recent of the doctors' cases, the case of 1952? It was a partnership that had been entered into just before the National Health Service, but it was in the Court and litigated in 1952. There the area was Atherstone and the period was, I think, five years, and the limitation of mileage was 10 miles. It would seem quite reasonable that a judge, when he is viewing these factors, views them from two angles, first of all the interest of the partnership that has been left, and the interest of the public. If it is in the public interest that there should be another doctor in an area that would be considered by the judge in the particular case. I do not see that there is

any very great hardship in these practices.—*Dr. Hilditch*: Was this a case of a partnership being broken?

2406. Yes.—The man who left had to give away his share of the practice, had he not.

2407. He was allowed under that rule to sell it, yes.—Well, he gave away a great deal, did he not? He gave away virtually his share of the practice.—*Dr. Russell*: More important, Sir, in the same circumstances now a partner would not be permitted to sell his share of the practice, he would just have to leave it and go. We have had one instance at least where a junior partner just had to leave the area.

2408. *Chairman*: You are not really asking, Dr. Russell, that there should be some right to allow anybody leaving a partnership and setting up next-door taking advantage of all that he learned from his partner, or are you actually going as far as that?—I think, firstly, that we would like to see a period in the practice before any restrictive covenant would apply. For example, if somebody is only two or three months in a practice, we think it would be unreasonable for a restrictive covenant to apply.

2409. Is that the period that you want, to confine it to three months?—I think we would have to define it, but we would like something over three months.

2410. Then after that you do not object to a reasonable radius and a reasonable period?—No.

2411. But you have not defined "reasonable". I do not think we will press you to that.—*Dr. Saudek*: The radius depends so much on the type of area.

Chairman: That is where the judge comes in, is it not?

2412. *Professor Jewkes*: Have you in fact any knowledge that the radius is generally too large?—*Dr. Russell*: The overall picture with the restriction of the Medical Practices Committee does make the radius larger from the point of view of the assistant. In actual practice we would say that in a densely populated area, perhaps in London, the radius for practical purposes could be measured in hundreds of yards, not in miles, as very often is the case. If one goes perhaps 300 yards away in London one is in virtually a different area as regards medi-

cal practice. From one's own experience, perhaps 80 or 90 per cent. of one's patients come from within a radius of a couple of hundred yards.

2413. *Chairman*: We had evidence two weeks ago from a dentist (which, of course, is not strictly relevant to your case) in Gloucestershire whose patients continued to come from as far away as Ascot and Dublin.—A dentist is not called upon to go out to the patients at night, whereas a doctor has to.

2414. *Professor Jewkes*: I have just got one point, which is on page 396 of your Memorandum. In the first paragraph you say: "Thus the established doctors will usually take what legitimate steps they can to try to keep out or squeeze out the newcomer". Could you tell us what you think the legitimate steps are?—*Dr. Hilditch*: One is to open up a branch surgery in a promising area. If you have got an area which is being developed, even on a small scale, say a new housing estate, there comes a point when it is worth while for somebody to start in practice, and you very often find that just before that point a branch surgery appears belonging to the local doctors. And, of course, once there is a branch surgery you have not a hope of building up a practice and making a living out of it within a reasonable time. That is one way.—*Dr. Russell*: Another way is, of course, the decision whether or not to advertise a vacancy, to decide whether a new area requires a new doctor, which is decided by the local Medical Committee, who are in fact directed by the doctors who are already practising in the area. It has come to our notice time and again that where a few hundred houses have been built, which might perhaps provide a list of patients of 1,500 or 2,000, the evidence from the local Medical Committee is that no doctor is required, and, of course, it is not fair to ask them to provide objective evidence on that.

2415. *Mr. Watson*: Would it be correct to say that the complaints you are now making are really that the decision is that of the local Medical Services Committee, which is subject to the scrutiny of the Medical Practices Committee?—The recommendation comes from the local Committee, the members of which are local practitioners, who are

virtually being asked, "Do you want more competition in your area?"

2416. So you need to inform your own Society rather than this Commission?—We did not raise this point.

2417. *Professor Jewkes*: You have raised it by making this statement.—*Dr. Hilditch*: May I quote the basis on which an area is designated or classified intermediate? It is not taken in by very small areas, it is taken as a very large one. I do not know quite what the basis is, but it is large enough anyhow to comprise 20 to 30 doctors, and it is done by rule of thumb. It is not done on the basis of the number of doctors to the number of patients, but the number of doctors to the number of patients who have already registered with one of the doctors in that area. If you get a big influx of 2,000 people and only 1,000 can register, then for classification purposes only 1,000 people are there, which very effectively makes sure that the established doctors have their lists nicely fixed up before there is any question of making an area designated.

Professor Jewkes: It affects the speed at which a newcomer could build up a practice in a reasonable time, of course.

2418. *Chairman*: Just on the remuneration point, we have not gone, and do not intend to go, through all those items on page 426 of your later memorandum, but I take it that in fact the operation of those other proposals, the extra payments for other services, maternity, for instance, and so forth, all have to be added on to this total shown in the graph you have prepared; they are all additional. That is right, I think, is it not?—*Dr. Segall*: Yes.—*Dr. Saudek*: As far as applicable, yes.

2419. Which is quite a bit on the total cost of the N.H.S. as a whole?—In the case of the rural practice, for example, we recommend a reduced maximum list.

2420. Yes, some of these things are reduced, but you want to dispose of the pool, and these points will be extra to what you have put on this chart?—*Dr. Segall*: Yes; the initial practice allowance, yes.

2421. *Professor Jewkes*: I was just going to link that question the Chairman has asked to what you said a moment or two ago. You really are

suggesting that the doctors who are sitting tenants do not particularly welcome a newcomer; but you also make a point in some places in this document that under the Central Pool system when a newcomer comes in £2,222 is added to the Central Pool, and it is, therefore, an advantage to the existing doctors. How do those two things work out? Why should doctors resist a newcomer if in fact they gain by it?—*Dr. Saudek*: It is an advantage to established doctors all over the country taken as a whole; but it is no particular advantage, or only a very small one, to the doctors in the immediate locality.—*Dr. Russell*: Of the 20,000 doctors in the National Health Service each one will get 1/20,000th of £2,222, but I do not think they regard that as a very great advantage compared with the possibility

of having somebody put up a plate next door.

2422. I accept that it means only a very small advantage to the existing doctors, but this is only a very small disadvantage to the operation of the Central Pool?—We are not opposing the Central Pool purely because of this.

2423. No; but I thought you did object to the Central Pool on the grounds that a newcomer brings in £2,222 to the total but does not draw £2,222 from it?—Yes.—*Dr. Saudek*: that is one effect.—*Dr. Russell*: We feel, in effect, that the method of the Central Pool as a whole is an illogical one.

Chairman: Then I think that is all we want from you. Thank you very much.

(The witnesses withdrew.)

Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

10—11

Tenth and Eleventh Days

Thursday, 13th March, 1958

Friday, 14th March, 1958

WITNESSES

Royal Faculty of Physicians and Surgeons
of Glasgow

Royal College of Surgeons of Edinburgh

Royal College of Physicians of Edinburgh

LONDON

HER MAJESTY'S STATIONERY OFFICE

1958

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Witnesses

ROYAL FACULTY OF PHYSICIANS AND SURGEONS OF GLASGOW

PROFESSOR S. ALSTEAD, M.D., F.R.F.P.S., F.R.C.P.	...	} Pages 461-497 Questions 2424-2665
DR. J. H. WRIGHT, F.R.F.P.S., F.R.C.P.	... ..
R. B. WRIGHT, Esq., O.B.E., D.S.O., Ch.M., F.R.F.P.S., F.R.C.S.	

ROYAL COLLEGE OF SURGEONS OF EDINBURGH

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MR. J. J. MASON BROWN, O.B.E., F.R.C.S.	

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DR. A. RAE GILCHRIST, M.D., F.R.C.P.	} Pages 533-575 Questions 2871-3029
DR. J. K. SLATER, O.B.E., M.D., F.R.C.P.	
DR. W. I. CARD, M.D., F.R.C.P.	... ..

MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

TENTH DAY

Thursday, 13th March, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MR. A. D. BONHAM-CARTER, T.D.

MR. I. D. MCINTOSH, M.A.

MR. J. H. GUNLAKE, C.B.E., F.L.A., F.S.S.

SIR DAVID HUGHES PARRY, Q.C.

PROFESSOR JOHN JEWKES, C.B.E.

SIR HUGH WATSON, D.K.S.

MR. S. WATSON, C.B.E.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

Explanatory Note by the Royal Commission

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence, to all representative medical organisations:—

- (i) The quality and quantity of recruits (*a*) offering themselves and (*b*) accepted for training as medical students.
- (ii) The quantity and quality of newly qualified doctors.
- (iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.
- (iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).
- (v) The position and prospects of a newly qualified doctor.
- (vi) Any trend to excessive resort to certain branches of the profession at the cost of others.
- (vii) The relative advantages and disadvantages, financial and otherwise, of service as:—
 - (*a*) a principal in single-handed general practice,
 - (*b*) a partner in general practice,
 - (*c*) a whole-time consultant in the National Health Service,
 - (*d*) a part-time consultant with the maximum number of sessions,
 - (*e*) a part-time consultant with only a few sessions,
 - (*f*) a Senior Hospital Medical Officer,
 - (*g*) a doctor in any other sort of practice or employment.
- (viii) The difficulties encountered by members of the registrar grades.
- (ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.
- (x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.
- (xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.

- (xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service.
- (xiii) Any anomalies in the methods of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume.
- (xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.
- (xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.
- (xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.
- (xvii) Special considerations of which account ought to be taken in discussions of medical remuneration.
- (xviii) Specific proposals for medical remuneration.
- (xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.
- (xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.
- (xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

Memorandum submitted by the Royal Faculty of Physicians and Surgeons of Glasgow

1. THE ROYAL FACULTY OF PHYSICIANS AND SURGEONS OF GLASGOW received its charter from King James VI just over three and a half centuries ago. The Faculty is unique among the Royal Medical Corporations in that it is empowered to grant after examination the diplomas of Fellowship *qua* Physician and of Fellowship *qua* Surgeon. It counts among its Fellows therefore the majority of practising consultants in medicine, surgery and obstetrics in the West of Scotland, in addition to large numbers of Fellows resident elsewhere in the United Kingdom and overseas. The Faculty is, in addition, a licensing body granting its Diploma (L.R.F.P. and S.G.) in conjunction with the Royal Colleges of Edinburgh, and so the Faculty, like other medical corporations, is also representative of general practitioners throughout the country.

2. In preparing this evidence for submission to the Royal Commission, the Faculty proposes to confine such evidence to matters relating to the hospital services and to base this written memorandum on the questionnaire addressed to the Faculty by the Chairman of the Commission.

Question I

"What is the quality and quantity of recruits (a) offering themselves, (b) accepted for training as medical students."

Answer

3. We have no exact data on which to answer this question. We understand that in Glasgow during recent years there has been a gradual reduction in the number of medical students. The number admitted annually is now about 160. Twenty-five per cent of the places are reserved for female students and some selection of candidates for these places has been possible. Little, if any, selection of male students has been necessary in the past few years.

Question II

"The quantity and quality of newly qualified doctors."

4. "Quality" is an attribute very difficult to assess and it may be dangerous to make the assessment at student level. The compulsory year of clinical responsibility in hospital has given the teachers a better opportunity to observe the capabilities of young graduates and, although we appreciate that "quality" varies from year to year, we are agreed that there has been no obvious change since 1948. It would indeed be surprising if such had been observed, for we believe that any changes which result from the introduction of a National Health Service will probably be slow in emerging.

5. Despite the increasing importance of the newer English Medical Schools, we would remind the Commission that the Scottish Medical Schools still train about one quarter of all British doctors. Many Scottish doctors must therefore find employment outside Scotland and there is special need to ensure that the present high standards are maintained.

Question III

"The wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation."

Answer

6. No comment.

Question IV

"The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them)."

Answer

7. The Faculty has not sufficient data to answer this question fully, but would make the following comments:

- (1) No student pays in University fees more than a small proportion of the cost of his education. The remainder is found from Exchequer grants, either to the University or to individual students.

- (2) There is a general feeling that the present duration of undergraduate training is too long. The Medical Course in Glasgow has been prolonged to six years. We would suggest that a serious attempt should be made to reduce the period of undergraduate training.

Question V

"The position and prospects of a newly qualified doctor."

Answer

8. The position of the young doctor immediately qualified is clear. Before registering he must spend two periods of six months as Resident in a recognised hospital—one period in medicine and one period in surgery. During this important formative phase of his training, and before he embarks on his individual career, he has to accept a good deal of clinical responsibility and it is probably true to say that this scheme is a great advance. His salary, after six years of training, is low compared to that in other professions. In accordance with the terms of his employment he is required to reside in hospital and to make a payment for his board and lodging. During his period in hospital he is permanently on call and this differentiates him from any other member of the hospital staff. We consider that the imposition of a compulsory charge for board and lodging in these circumstances is unjustifiable.

9. Normally at the end of one year his name will be added to the Medical Register. He will then be called up for Military Service for two years, and during this time he will probably decide whether to seek a career in general practice, to train for a specialty, or to enter some other branch of medicine. It is most unfortunate that the rigidity of the present system imposes this choice at such an early stage. Should he decide to go into general practice, he will apply for a post as a trainee or assistant. If, after a period of trial, he finds that he would prefer to be in the Hospital Service, he will discover that it is very difficult to enter it in competition with those already in that Service. If he succeeds, it will be at considerable financial sacrifice.

10. Equally disturbing is the plight of the trainee in the Hospital Service who either fails to gain advancement or desires to change over to another specialty or to general practice. There is a definite impression that some Executive Councils virtually exclude registrars from consideration when filling vacancies in general practice. This tempts young doctors to enter general practice after only one year in resident posts in hospital and without a sufficiently broad hospital training.

11. The salary of a Junior Hospital Officer after registration should be raised to a level comparable to that of a trainee assistant in general practice. While the ultimate prospects for the successful consultant in the Hospital Service are reasonably good, the conditions during the training years (25–35) are very unattractive and cause considerable financial hardship and much frustration.

Question VI

"Any trend to excessive resort to certain branches of the profession at the cost of others."

Answer

12. For some years, there has been an increasing dearth of candidates for certain specialties (e.g. Radiology, Radiotherapy, Ophthalmology, Psychiatry and Diseases of the Ear, Nose and Throat). In several of these the shortage is already a serious problem. Young men tend to prefer the wider fields to these relatively narrow specialties and when a shortage occurs these subjects are invariably the first to suffer.

13. In the case of medicine and surgery, a similar situation has now arisen with certain appointments about registrar level in non-teaching hospitals. In the major teaching hospitals, which have always been regarded as offering the most desirable junior training and experience, there have recently been junior posts in major specialties for which the applicants were only sufficient in number to fill the vacancies.

14. These data do not of themselves prove a resort to other branches. They do, however, suffice to show that recruitment to the hospital side of the Service is insufficient to meet the calculated needs of the Service, and that competition is not sufficient to maintain the desirable standards.

Question VII

"The relative advantages and disadvantages, financial and otherwise, of service as:

- (a) a principal in single-handed general practice.
- (b) a partner in general practice.
- (c) a whole-time consultant in the National Health Service.
- (d) a part-time consultant with the maximum number of sessions.
- (e) a part-time consultant with only a few sessions.
- (f) a Senior Hospital Medical Officer.
- (g) a doctor in any other sort of practice or employment."

Answer

- (a) No comment.
- (b) No comment.
- (c), (d) and (e)—

15. The Faculty is unwilling to regard these questions as separate and distinct. It would point out that what are "advantages" to those in (c) may well be regarded "disadvantages" by those in (d).

16. One of the better features of the National Health Service is that the conditions allow the consultant to practise either whole-time or part-time. The value of this position lies in the fact that it allows a consultant to choose the form of service which suits his own particular temperament and gives the patient a freedom of choice of specialists which would otherwise be unobtainable. As the relationship between consultant and patient should always be to some extent personal and humanistic, it follows that the advantages or disadvantages of one or other form of service (whole- or part-time) will appear differently to doctors of different temperaments. Thus, there can be no uniformity of opinion on advantages or disadvantages.

17. Many influences serve to direct the doctor to a particular form of hospital practice; chance, a desire to pursue a specialty such as laboratory medicine where the posts are full-time, geographical conditions, domestic considerations, personal economics, or a liking for a particular type of life—all or any of these and possibly others enter into the decision. We consider it desirable to express the view that facilities should exist in hospital practice for each type of work. We would urge most strongly that it would be entirely wrong to consider that one form is "better" than another, or that all doctors should be expected to undertake their work under the same conditions. We believe it is undesirable to imply that there is some fundamental difference between those who prefer whole-time and those who prefer part-time work.

18. The total number of consultants in the Western Region of Scotland is 444. The majority of the 237 consultants on a part-time basis in this Region are on 6-8 sessions. 67 are employed on a basis of 9 sessions per week; only 13 are employed on the basis of less than 5 sessions per week. We would point out that at least in this Region the majority of doctors in clinical hospital practice do not fall into any of the categories defined in (c), (d) and (e).

19. We consider that it is a serious disadvantage that, at least in Scotland, all training posts are full-time. We adduce the following reasons for this view:

First—the number of full-time consultant posts, and especially of those involving charge of wards, is small compared with those which are part-time. As a result, if appointment to a part-time post is delayed into the forties, a doctor may find that on promotion he has to suffer immediate financial loss, not only in monetary salary, but also through the need to open private consulting rooms, knowing that it may be several years before he builds up a sufficient practice to compensate.

Second—we believe that there may ultimately be real disadvantages to the Service as a whole if the doctor, during his training period, is confined to hospital practice. A valuable part of the training of the future consultant lies in learning to deal with illness in the home, and in collaborating with the general practitioner and so appreciating his difficulties. We would suggest that it would be advantageous if those who had completed their period of training could be encouraged to take part-time posts as senior registrars.

20. By conducting a fairly wide enquiry among whole-time and part-time specialists, the Faculty has elicited the following information as evidence of some of the more prominent features of the terms of service which appeal to one or other section of the consultant community—whole-time or part-time.

- (1) There are those who have found in whole-time service financial security, in that they can budget upon a fixed income in which the ceiling is known and the pension rights are defined.

In contra-distinction, there are those who feel satisfied with a lower (part-time) ceiling of income and pension, always provided they have the freedom to augment these, should they so desire, by working outside the Health Service.

- (2) There are those who find the terms of whole-time service conducive to the peace of mind necessary for the conduct of research; this seems to apply particularly to many academic workers.

Equally, there are others who find such terms irksome and who are stimulated by the freedom of part-time occupation; to such, competition is exhilarating.

It must be remembered that valuable contributions to research emanate from both sources.

- (3) Some whole-time consultants feel that whole-time work offers greater leisure and domestic freedom and that their work and life can be organised within a specific pattern. Other consultants claim these advantages for part-time practice. A third group, comprising both whole-time and part-time consultants, maintain that their way of life is unfettered by distraction and allows them freedom to pursue their career.
- (4) Some whole-time consultants feel it a grievance that they receive no extra payment from the University for clinical teaching.
- (5) Some whole-time consultants consider it unjust that they receive no payment for the first eight domiciliary visits in each quarter.

There is a large measure of agreement from all sources that certain anomalies and disadvantages exist under the terms of service and these appear to be largely financial and related to Income Tax regulations:

(i) *Freedom to change terms of service.*

The freedom of a whole-time consultant to change to maximum part-time service and vice versa is too limited. Moreover, there is, at present, the limitation of appointment in part-time service in the West of Scotland to those of consultant and S.H.M.O. status only. This deprives the junior ranks of the hospital staff of the opportunity to initiate a private practice or to gain any experience in this field.

(ii) *Allotment of sessions.*

There is a lack of uniformity throughout the country in the allocation of sessions for equal work. It is notable that seven, or at most eight, sessions is the rule in certain areas, whereas maximum sessions is the common experience in others.

(iii) *Car Allowance.*

It is unrealistic to suppose that the whole-time consultant should not have a car and use it every day. Public transport is too slow, too uncertain, and sometimes too expensive to be relied upon in the conduct of a consultant medical practice. Even where car allowances are obtained, these are unrealistic under the terms of depreciation and replacement. The necessity to provide and maintain a car for use in emergency and other routine medical duties weighs heavily on whole-time staff, and this is particularly so in the case of junior whole-time staff who frequently have many emergency calls to answer; it is particularly heavy where the mileage is small.

(iv) *Scientific periodicals and attendance at professional meetings.*

As a whole-time consultant is prohibited from charging these expenses against his Income Tax and may have to meet them out of his own pocket, there is a tendency to avoid such expenses. It should be realised that expense incurred in these respects greatly improves the quality of the Service.

(v) *Entertainment expenses.*

The free interchange of consultants, both nationally and internationally, is of inestimable value to the community and it would be reasonable that a small entertainment allowance be permissible as a deduction from Income Tax as is the case in the United States and elsewhere.

- (6) At present, the disadvantages of the Senior Hospital Medical Officer are similar to those of the whole-time consultant with, in many cases, the additional feeling of grievance that he is performing similar duties for a lesser salary.
- (7) Members of the medical profession superannuated under the National Health Service Scheme who are subsequently appointed to University posts should not be compelled to leave the N.H.S. scheme and to join the F.S.S.U. Such an alteration may cause considerable financial loss to the individual particularly if he subsequently returns to National Health Service employment.

Question VIII

"The difficulties encountered by doctors of the registrar grade."

Answer

21. These derive from the rigidity of the present system of advancement, from the fact that the great majority of consultant posts are held by persons who have still fifteen or more years to serve, and from a failure of the employing authorities to absorb registrars into the general practitioner service. The registrar can have only one salary increment and must then remain on a low fixed income until he gains a senior registrar post. During these waiting years, his domestic commitments are almost certainly increasing, he is striving to obtain higher degrees and publish original work (both expensive items), and his valuable contribution to the Service is steadily increasing. Yet he has no security of tenure and no additional rewards. If he decides to try an alternative specialty, he will be no better off financially, and perhaps initially worse. If he tries to enter general practice, he will have to sacrifice considerably and probably accept a trainee assistant post. After a lapse of several years, he may obtain a post as senior registrar and for four years he will receive an annual increment to his salary, but now, aged 35 or more, he is carrying a heavy load of clinical responsibility and is often a highly skilled technical specialist. He reaches a salary ceiling of £1,540 per annum and can look forward to a further period of intense frustration whilst waiting hopefully for a consultant post. It will be remembered that in terms of the Spens Report such a man might have expected to reach consultant status by the age of 32 and to be already receiving a salary which, adjusted to the 1956 equivalent, would be £2,625 per annum. As the years pass, the specialist trainee's total life-earnings shrink considerably from the expectations based on the Spens Report and its theoretical scheme of advancement.

22. During the three year period up to the end of 1955 only 23, out of a total establishment of 130 Senior Registrars in this Region, attained consultant status.

23. This prospect is even more disturbing when it is considered that other outlets, such as the Services, the Dominions, and the Colonies, are much reduced. The change to another specialty or to general practice is even more difficult for the senior registrar than for the registrar. If successful, it deprives the Hospital Service of a highly trained man resulting in both individual and collective loss.

24. It is realised that in the Hospital Service there will always be required an excess of persons in non-consultant posts. There must always be a reserve of potential consultants, adequately trained to take over full consultant duties. These specialists, already performing highly skilled professional duties and accepting final clinical responsibility, should be appropriately paid. In order to minimise frustration and even hardship and adequately

to reward service actually rendered, it is suggested that registrar posts be tenable for two years. After this period of training the registrar would obtain no increase in salary unless he obtained a post as a Specialist. In this grade, which would absorb and replace present senior registrar and S.H.M.O. grades, and appointment to which would be by selection after advertisement, the specialist would have security and his salary would rise by annual increments until just short of consultant level. Further promotion would be by appointment to advertised vacancies.

25. Fears that the authorities, influenced by consideration of economy, might try to reduce the number of consultant posts and run the service largely on specialists in the new grade—the major criticism of the Strachan Report proposals—could be overcome by initial agreement on an adequate consultant establishment and the subsequent periodic review of this by an Establishments Committee.

26. The main points in this scheme are:

- (a) Registrars are to be regarded as trainees and accepting only limited responsibility, as in temporary employment and expendable, and dependent for promotion on success in keen competition. Steps must be taken to ensure that they do not suffer if they have to diverge to general practice or some other branch of the Service.
- (b) Senior Registrars and S.H.M.O.'s would be absorbed into a new career grade which would eventually become a temporary grade for the majority and a permanent one for a few.

27. We believe that the number of posts in this new grade should be strictly limited and mostly in the teaching hospitals. It should not be used to dilute the total consultant establishment. The Faculty is most seriously concerned by the sense of insecurity which is so widespread among Senior Registrars and which is so detrimental to the individual and the Service. It cannot be too strongly emphasised that by the time the specialist has completed four years in the present Senior Registrar grade he has acquired a most valuable training and is making a very valuable contribution to the hospital service.

Question IX

"The difficulties of entering general practice with special reference to the position and prospects, financial and otherwise of assistants."

Answer

28. We have no comment except to stress the difficulties experienced by registrars attempting to secure posts in general practice.

Question X

"The importance of private consulting practice as an incentive to entering the consultant branch of medicine."

Answer

29. (1) This offers for a very few specialists the highest financial rewards obtainable in the profession.

(2) Private consulting practice ensures for the patient and general practitioner the possibility of complete freedom of choice of consultant and this is a powerful safeguard of doctor-patient relationship.

(3) Private practice affords an extra stimulus to some to strive constantly to improve their knowledge and technique and to attain and maintain the highest professional standards.

(4) Private practice affords the best opportunity for specialists to meet and treat patients in their own homes, in nursing homes or pay beds, and in private consulting rooms; and for patients who wish special privacy to be seen in their own homes or in private consulting rooms unconnected with the officialdom and the occasional impersonality of hospital departments. There is an increasing body of persons who desire private medical care.

(5) Private practice allows the patient to claim, during any illness, the continued individual attention of his chosen consultant.

(6) Private practice allows and encourages the individual consultant to progress in his profession by his own efforts and along his own chosen path.

30. Under present conditions in Scotland, the incentive of private practice is denied until the specialist reaches consultant or S.H.M.O. grading. If he does not do so until he has passed the age of 40, he may suffer financial hardship until he can build up a reasonable income from private practice (see answer to Question VII). During this phase he may find himself in the position of being in receipt of a lower income than junior colleagues in his own unit.

Question XI

"Expenses in general practice."

Answer

31. No comment.

Question XII

"Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time in the National Health Service."

Answer

32. Reference has already been made to this in answer to Question VII.

As far as remuneration from the National Health Service is concerned, both groups are subjected to P.A.Y.E. Necessary professional expenses are allowed to part-time consultants only against income from the private practice under Schedule D.

Question XIII

"Any anomalies in the methods of payment of any branch of the profession."

Answer

33. No comment.

Question XIV

"Comment on the present method of calculation and distributing the general practitioner's remuneration through a central pool."

Answer

34. No comment.

Question XV

"General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system."

Answer

35. While we have no suggestions for an alternative system, we feel that the method of allocation should be made more widely known. It is recognised that secrecy is essential if those who are not in possession of such awards (66 per cent of all consultants) are not to be compared by the public unfavourably with others who are the recipients of awards. Awards without secrecy would not merely reward one group but would *pari passu* detract from the status of others.

36. There would appear to be room for a greater allocation of merit awards to Scotland where the four Medical Schools train about one quarter of the United Kingdom total of medical students.

Question XVI

"Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners."

Answer

37. The situation of the registrar of more than four years standing in that grade or the senior registrar of five or six or more years standing in that grade is one of increasing

liability at home, increasing responsibility and effectiveness in the hospital and progressively depreciating economic status, e.g.:

- (1) In terms of the Spens recommendation, a senior registrar, aged 28, would have received £900 (1939 value). The 1956 equivalent would be £2,304; his actual present salary is £1,210.
- (2) A senior registrar in his fourth year would have received £1,200 (1939 value). The 1956 equivalent would be £3,072; his present salary is £1,540.
- (3) It must be stressed that few senior registrars attain this maximum salary by the age of 31 and many remain at this salary ceiling for several years. The normal range of age of a senior registrar envisaged in the Spens Report is 28 to 32. The average age of senior registrars in this Region is 35.

38. We quote three sample budgets:

A.

Budget for year 1956-57 for a Senior Registrar aged 37, with two children, ages 9 and 5. Qualified 15 years, in 6th year of service as senior registrar.

	£	s.	d.	£	s.	d.
Salary				1,540	0	0
Deductions: N.H.I. contributions	15	0	0			
Superannuation	92	8	0			
Income Tax	277	12	0			
				385	0	0
Net income after deductions				£1,155	0	0

Expenditure:

1. Rent of house, coal, electricity	250	0	0
2. Car, repairs, petrol, tax and insurance, less mileage allowance £50 (car two years old)	82	0	0
3. Telephone, subscriptions, books, etc.	54	0	0
4. Interest on borrowed capital	47	0	0
5. Insurance, personal and property	123	0	0
Total	£556	0	0

Remainder available for food, clothes, education of children, repayment of borrowed capital, holidays, entertainment per annum	£599	0	0
or, approx., per week	£11	10	0

B.

Budget for 1956-57 for a Senior Registrar aged 39, with three children, ages 9, 7 and 5. Qualified 15 years, in 7th year as a senior registrar.

	£	s.	d.	£	s.	d.
Salary				1,540	0	0
Deductions: N.H.I. contributions	15	0	0			
Superannuation	92	8	0			
Income Tax	193	16	0			
				301	4	0
Net income after deductions				£1,238	16	0

<i>Expenditure:</i>	£	s.	d.
1. Rates for house, coal, electricity, house repairs and property tax...	221	5	3
2. Car (4 years old), repairs, petrol, tax and insurance (less mileage allowance £60)	89	7	6
3. Telephone, subscriptions, books, applications	48	18	9
4. Interest on borrowed capital	44	0	0
5. Insurance, personal and property	41	0	0
6. Education—3 children at day school	134	13	10
	£579	5	4

Remainder available for clothing, food, domestic help, holidays	per annum	£659	10	8
or, approx., per week		£12	10	0

C.
Budget for year 1956-57 for a Registrar, aged 34, during 7th year of service as a registrar and 12 years after qualifying. Married. No family.

	£	s.	d.	£	s.	d.
Salary				1,061	10	0
Deductions: N.H.L. contributions	15	0	0			
Superannuation	60	0	0			
Income Tax	130	10	0			
				205	10	0
Net income after deductions				£856	0	0

<i>Expenditure:</i>	£	s.	d.
1. Rates for house, coal, electricity, house repairs	180	0	0
2. Car: Petrol, tax, insurance, repairs, less mileage allowance £40 (car one year old)	88	0	0
3. Telephone, subscriptions, books	41	0	0
4. Payment of building society loan	161	0	0
5. Insurance, personal and property	60	0	0
	£530	0	0

Remainder for clothing, food, holidays	per annum	£326	0	0
or, approx., per week		£6	0	0

Question XVII

"Special conditions of which account must be taken in discussion on medical remuneration."

Answer

39. (1) No other occupation carries so great immediate responsibility for human life.
- (2) A doctor's hours of work are long and irregular and impose a great physical and mental strain; his services have to be available at all times day and night.
- (3) The medical man must spend much of his leisure time in further study.
- (4) The medical curriculum being longer than most, the medical graduate will generally be older than those who graduate in other Faculties at the same time.
- (5) Before the advent of the National Health Service, the doctor had achieved an honoured status in society as a man of learning, culture and especial responsibility. We believe it is important to the maintenance of high professional and ethical standards that this status should not be undermined by the inadequacy of his financial reward.

(6) The necessity for constant attention at the telephone is extremely important and the doctor's home life can be well nigh intolerable without adequate domestic help which is becoming increasingly costly.

(7) In most branches of hospital practice it is essential to possess a motor car.

(8) In the Hospital Service a particular source of expense may be involved in moving house on frequent occasions during the early training years when income is low and no allowance or compensation for such necessary movement is made.

Question XVIII

" Specific proposals for medical remuneration."

Answer

40. The Royal Faculty supports the Negotiating Committee in their claims for increased remuneration based on the change in the value of money. We have already stressed that the most acute financial distress arises in the training years. We feel that within the general claim a mechanism should be sought which would take account of the serious " ageing " of the registrars, senior registrars, and " young " consultants. Our specific proposals are:

- (1) The salary of the Junior House Officer should not be subject to any deduction for board and lodging.
- (2) The Junior House Officer after registration should be paid a salary comparable to that of a trainee assistant in general practice.
- (3) Senior Registrars and Senior Hospital Medical Officers should be absorbed into a Specialist grade, strictly limited in numbers, and paid a salary which rises by annual increments to a level just short of the lowest level for consultants.

All present Senior Registrars and Senior Hospital Medical Officers so absorbed should be given credit for their length of service when their starting salary in the new grade is determined.

- (4) Registrars should be appointed to Regional establishments and all have the opportunity of working in both teaching and non-teaching hospitals. Living accommodation and, if necessary, married quarters would require to be provided by the Regional Boards because compulsory change of domicile can involve considerable financial hardship. The registrar posts should be tenable for two years only with a salary scale of £1,000 per annum first year and £1,250 per annum second year, the scale to be adjusted in relation to the purchasing power of money.
- (5) Registrars and " Specialists " should be given the opportunity of taking up part-time practice so that these young men might undertake work in other departments of the hospital or University, at medical boards, or in general practice or be free to do domiciliary consultations or private practice according to their desires or bent.
- (6) The basic consultant salary should take account of the fact that most consultants are aged 36 when they obtain their first appointment, and we suggest that the initial starting salary should be calculated on this basis (e.g. on the present scale, this would be £2,730 at age 36).
- (7) We consider that all salary scales should be raised to take account of the fall in the value of money since these scales were determined.
- (8) We consider that the Establishment of consultant strength for a region should be based on the number of sessions rather than the number of consultants.

Question XIX

" Fixed scale for assistants in general practice."

Answer

41. No comment.

Question XX

"Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration."

Answer

42. We would suggest that the whole conduct of the National Health Service, including remuneration, should be divorced from direct Parliamentary control and possible political prejudice. An autonomous Corporation representative of the Public, the Profession, and the Government should be set up to administer the Health Service. It is suggested that representatives of this body should visit Scandinavia, Australia, New Zealand and U.S.A. to study their medical services at first hand and thereafter initiate such modifications of the present Service as they consider advantageous.

43. Regular review of medical remuneration should be undertaken by the Corporation in consultation with the appointed representatives of the profession. Should disagreements arise, the question could be submitted to arbitration on the initiative of either party.

Question XXI

"Any factors other than remuneration which are affecting the contentment of general practitioners."

Answer

44. No comment.

Examination of Witnesses

PROFESSOR S. ALSTEAD (*President*)

DR. J. H. WRIGHT

MR. R. B. WRIGHT

on behalf of the Royal Faculty of Physicians and Surgeons of Glasgow.

Called and Examined

2424. *Chairman:* Professor Alstead, you are the President of the Royal Faculty?—*Professor Alstead:* That is so.

2425. And you will be acting principally as the spokesman, will you?—We would prefer, Sir, to divide the responsibility for the answers according to our special interest in the matters raised.

2426. Thank you. You will find you will be asked questions by many members of the Commission, but for convenience we have divided much of our work between two sub-committees. As you may know we have two important lawyers on the Commission in this particular case, Sir David Hughes Parry has been Chairman of the sub-committee which has been studying your evidence and will do most of the questioning. I hope I do not need to tell you that we will be asking some fairly thorough questions on many points, but that does not imply hostility or disbelief. If we do

not ask questions nobody else will. Equally if there are points that we may seem to be ignoring that does not mean we are accepting them, but it may be that some of the points are outside our terms of reference or sufficiently covered in the very many submissions we have had from other people.

Just as a start and really for the record would you tell us about the Faculty, what is its membership, its governing body, and so forth?—The Faculty, Sir, is a Medical Corporation and its history goes back for rather more than three and a half centuries. It was founded under charter obtained from King James VI and our first president had as his ambition to regularise medical practice in the West of Scotland. That was achieved as a result of the granting of the charter, and the work of the Faculty has proceeded on those lines for three and a half centuries. The Faculty is in fact best described as a licensing body; its main function has been to give

licences to practice to suitably trained and suitably qualified candidates. It has of course exercised two functions. It has been a teaching body and a licensing body. But its function changed substantially some ten years ago when the responsibility for teaching medical students was centralised in the University. So we are no longer responsible for teaching, although we are still a licensing body and we are in a position to grant licences to candidates who sit out examination jointly with those of the Royal Corporations of Edinburgh, the qualification being the triple qualification. But in fact following upon the centralisation of teaching within the universities in Scotland the function of the Royal Faculty has been diverted to post-graduate education and we grant post-graduate diplomas principally to specialist physicians and specialist surgeons. This is the Fellowship of the Royal Faculty of Physicians and Surgeons and this Fellowship may be qua physician or qua surgeon. There are several other post-graduate diplomas in dentistry, in public health and in child-health. This then is the main function of the Royal Faculty of Physicians and Surgeons at present: post-graduate education and the granting of post-graduate qualifications. Our position in this field is, as we say in our introductory paragraph, unique in that the physicians and surgeons are housed under one roof, but we function within the Faculty in a sense separately in so far as the award of post-graduate diplomas is concerned but jointly in so far as administration is concerned. If one were to try to think of something analogous in Edinburgh one would have to combine the Royal College of Physicians and the Royal College of Surgeons under one roof—though that might call for a little imagination.

2427. They are both coming here tomorrow as a matter of fact separately. —Yes, Sir. Now I think, Sir, that this is perhaps as much as I need to say about the status of the Faculty among other Medical Corporations and our function in medical teaching.

2428. Have you many more physicians than surgeons or the other way round? —I cannot give you offhand the numbers of each, but we have some 800 Fellows of the Faculty. About half of these are in Scotland, most of them in

the West of Scotland, and the other 400 are scattered throughout the world.

2429. What is the constitution of the governing body, as it were, of the Royal Faculty?—We have a council of the Faculty elected by the Fellows at their annual meeting and this constitutes some 16 members, Fellows of the Faculty.

2430. Which includes both physicians and surgeons?—It does, Sir.

2431. But not in any prescribed proportions?—No, although the Fellows in general take note of the need to have reasonably equal representation.

Chairman: I think that gives the general background; thank you very much. Now, Sir David.

2432. *Sir David Hughes Parry:* The Royal Commission put a number of questions to the Faculty for their consideration and you have very kindly provided your written evidence in the form of answers to those questions.—Yes, Sir.

2433. I think it would be convenient to us, if convenient to you, that we ask you to elaborate or expand some of the answers you have frankly provided. Would that be all right?—We would be very happy to try.

2434. The first question related to the quantity and quality of the recruits that have been offering themselves of recent years for training as medical students. Of those that have been accepted you say in the last sentence of your answer that little, if any, selection of male students has been necessary in the past few years. Now is that special to one medical school or does it apply to Scotland generally?—I have no exact information about other medical schools, Sir, but in Glasgow, with the falling number of applicants for the available places, there has of course been diminishing latitude in regard to the selection. In other words we have, say, at the most 200 places to offer. On some occasions we have had as many as, say, 700 applications for these 200 places. Competition was then very keen, but since the number fell to about half that number—maybe 300 applicants—and since some of the applicants were obviously unsuitable then obviously the competition became less keen.

2435. Your entry in Glasgow is about 200 a year, is it?—In the current year I have a figure of 163 students.

2436. *Chairman*: You give 160 in your evidence.—Yes, the number admitted annually is now 160. That appears in paragraph 3 of our answer. That is intended to be a mean and I may say, Sir, in making these statements we are making them as the Faculty of Physicians and Surgeons and we are commenting on the practice of the University in our own city with which we have no real association except we are within it.

2437. *Sir Hugh Watson*: Does that mean you have not in fact obtained exact figures from the University?—We have attempted to get some information from the University, but we have the impression that the officials in the University believe they may be asked direct for this information, and that being so perhaps are a little reluctant to give us precise details.

2438. *Sir David Hughes Parry*: May I take it one step further? Do you think on the whole all the male students that apply and are fully qualified are accepted?—That is the general trend, Sir.

2439. But in the case of the women students there is some choice?—That is so, Sir, because of course the number of places reserved for the women is fixed at a fraction of the total number of places offered.

2440. Who decides how many places women should have?—I speak as a Professor within the University but not with the authority of an official in the University. Some arbitrary decision is made by, I imagine, the Court or Senate, and the medical faculty within the University, as to what proportion of students should be male and what female. Automatically a quarter of the places are reserved for women students.

2441. It follows from that that there may be better women students than male students who fail to get admission?—That is so in my opinion.

2442. Would you think that is a good thing?—Intrinsically I would say, no; but taking the long term view it is a reasonable thing to do.

2443. *Mr. Bonham Carter*: On the grounds, I take it, that the career is a shorter one?—Yes because after all the medical service has to be staffed. If

for example we take an extreme view that 90 per cent. of our students were women the service would obviously be understaffed within a few years.

2444. *Sir David Hughes Parry*: Can we move to your answer 4 as to quality? You come to the conclusion on the whole there has been no obvious change since the introduction of the National Health Service.—Answer 4 says that there has been no obvious change since 1948.

2445. That is your impression, is it?—Yes.

2446. Then in answer 5 you emphasise that you still train about one quarter of all British doctors, and that fact I think you make use of at a later stage when you refer to merit awards?—Yes.

2447. Do you train on the whole more or less than formerly? Have the numbers at Glasgow fallen?—The numbers of students entering the medical faculty have fallen from something like 200 or 190 down to a level of 160.

2448. Is that deliberate policy?—I think it is partly deliberate policy because we regard 200 as too many to be adequately dealt with by existing staff and facilities for teaching, but it is also partly attributable to the state of affairs referred to earlier, that there is not a large enough number of well-qualified students coming forward.

2449. There is some feeling that has been expressed that the system of training in Scotland is largely different from the system of training in England. Is there anything in that suggestion?—I think there is, and perhaps if I may make a personal remark as an Englishman trained in an English University and having had the good fortune to be elected to the staff of a Scottish University, I can speak with personal experience. There are some differences. Would you like me to comment on them?

2450. It does become rather important if we are going to examine the clinical material that may be available in the area.—Yes, Sir.

2451. Where there still may not be too many being trained for the clinical material that is available. I would like you to explain.—I wonder if I might take the last point first and say in my opinion—and I imagine my colleagues

share this opinion—there is no shortage of clinical material, certainly in the West of Scotland, for teaching as many as 200 students in a year if we were to make the fullest use of all the opportunities that are available to us. But the mere existence of a large number of sick people requiring expert medical care does not in itself satisfy all the requirements. Quite clearly that is just the beginning of the problem. The provision of adequately trained registrars and senior registrars, consultants and other specialists, also requires to be dealt with. And that is a long term policy, something that must be anticipated—something which might require five or even ten years to mature. Reverting to the other point, Sir, comparison between the Scottish system of training and the English system, I should say that in general there is a closer supervision of the Scottish medical student in the wards of the hospital. There is more systematic instruction of the medical student at stated hours during the day. On the other hand, until the National Health Service began I think it true to say that as far as outpatient teaching is concerned, the English system was somewhat better than the Scottish one in that the staffing of outpatient departments in the English teaching hospitals was undertaken by more senior members of the profession than we had in Scotland. But there has been a tendency as far as outpatient practice is concerned for that difference to be eliminated.

2452. I would like to press you on one matter. There is an impression perhaps that the clinical experience and responsibility of the English trained doctor may be a little greater than that of the Scottish trained doctor. Is that so? —I am not quite prepared to accept that. I think probably the opinion derives from the fact that if the student in England is not under as close supervision as he is in Scotland, if he is in fact allowed more liberty, more freedom of movement within the hospital, then the student himself, if he is the right kind of student, will take the initiative in finding the experience that he requires. The good student will and of course the bad student will not. That may appeal to certain temperaments just as closer supervision may appeal to other temperaments among students.

2453. I will just move forward, still in the same field to answer 7. Now you suggest that there is a general feeling that the present duration of undergraduate training is too long. You say that the medical course in Glasgow has been prolonged to six years. At what age do the students enter the medical faculty? Is it 17½?—17½ to 18, yes.

2454. The English student tends to enter at 18 to 19?—Yes, Sir.

2455. The Scottish student will probably be a year younger?—Yes, that is so. May I develop that?

2456. Yes, certainly.—There is a large proportion of the English student body who in fact stay in the sixth form at school, the extra year, in order to take their chemistry, physics and biology to first year M.B. level and gain exemption from that part of the medical curriculum. I think I am right in saying that that concession is being withdrawn in some of the English schools, but I speak subject to correction there. That on the whole does account for a different age of starting. The Scottish student is encouraged to come up a year earlier having a certificate of fitness for University education in order that he may cope with his last year at school and his transfer to the first year at the University.

2457. Which is a little more expensive to the community?—That is so.

2458. *Chairman*: But they will qualify at the same age, will they?—They will qualify at the same age. It depends on whether they get exemption from the first year in England. They can qualify in five years.

2459. Five and a half years, I think.—Five and a half years. Yes, there is a little difference.

2460. You have mentioned, Professor Alstead, that the Scottish Medical Schools still train about one quarter of all British doctors. That has been the tradition for a long time?—Yes.

2461. That includes students from England as well as the Scottish ones? —Yes. It is a mixed population of students but in Glasgow the vast majority are from the West of Scotland, just a few from the North of England. By contrast—I think I am right in saying this—there is a very substantial proportion of the students at St. Andrews University who are English.

2462. And the same sort of thing applies in some other occupations, for instance, accountancy?—That is so. It is part of the Scottish tradition.

2463. And for exports to be not only to England but overseas as well?—Yes, Sir.

2464. You do not think there is a trend towards any material change?—I think that with the increasing importance of the Universities of the North of England and the intake which may be as many as 100 students per year at each of the northern Universities of England, quite clearly the need for such a large number of students in the Scottish schools diminishes, if in fact there is a limit to the total intake for the whole profession.

2465. There would seem from a table in the evidence given to us by the Royal College of Physicians of Edinburgh to have been an increase in the number of Scottish graduates compared with 1934 in recent years, but a considerable decrease in the percentage.—Dr. Wright is a Fellow of the College and a member of the Faculty Committee. He has this document before him and might speak on this point.—Dr. Wright: I think you are actually referring to the standard figures to show there is a very considerable rise in the English figures from 847 to 1,848. From 1934 to 1952 the Scottish figures have risen from 471 to 673, a very decidedly lower increase.

2466. And in fact the Irish figures have risen even more sharply.—From 154 to 506.

2467. Do you feel there is any special significance in those figures?—I think the main significance Professor Alstead has already mentioned, namely the gradual growth of the—shall we call them provincial Universities of England—the increasing importance of these and their recognition as very important training centres in medicine.

2468. Sir Hugh Watson: Have you any more recent figures—the ones we have go to 1952 as you know—which will tell whether this trend is being continued?—We thought such information might be forthcoming from Universities. We had the impression they would be offering the evidence and this would be an important part of their evidence. I should say the figures will

not vary very much because the agreed figures for intake for Edinburgh and Glasgow are about 160.

2469. Chairman: The percentage might vary in Ireland?—We can offer no evidence on what is happening in Ireland.

2470. Mr. Gunlake: Do you feel that any falling off there may be in the number of medical students is associated in any way with the scientifically minded young man being attracted into other fields—physics, etc.?—Professor Alstead: I think it might well be so because the other professions—physics, applied physics and so on—in these days surely are very attractive to the enterprising schoolboy and the young man. By comparison he is confronted by the medical curriculum lasting six years after a fearfully arduous preparation in school; then a year's residence in a hospital; two years in the Army; then perhaps a year in which to settle down to civilian life and perhaps suffer some disillusionment in his attempts to find a place in general practice.

2471. Would you feel one of the factors in their minds might be a question of remuneration over the whole course of the career?—Quite honestly I do not think the Scottish schoolboy and the young graduate think very much about remuneration.

2472. Mr. Bonham Carter: On the other hand would you consider he is thinking about the difficulty of getting the proper job at the end of all those things you have mentioned—training, National Service?—Yes. I think he is bound naturally to be very much in touch with those who were a few years ahead of him at school. He would watch their careers, note the situation they are in after nearly ten years of training, and then say: "Well, if that is the kind of thing that happens to the young doctor I had better go in for physics."

2473. He would lay more stress on that than the possible plums which the other careers, other scientific careers, are at this moment offering, would he?—I think so, yes.

2474. Professor Jewkes: I wonder if you could tell us why you think the present duration of undergraduate training is too long? We are sometimes told there is more and more to learn in

medicine all the time. One might think more could be learned in six years than five. What is the drawback?—I suppose any comment that one may make on this subject is to some extent arbitrary. There is probably no such thing as the right amount of time to be devoted to the medical course because we are dealing with only one of a large number of variables. I think that one can of course look at the extremes. Suppose we devise a medical curriculum to last three years. I am quite sure in my mind that would be totally inadequate. Suppose we devise one to last ten years. I am equally sure we should get a bad doctor at the end of it; because although we may pump a lot of information into him at the same time we would probably extinguish his native wit, and to that extent he would be a fairly useless sort of creature when we had finished with him. So I think there is some sort of middle way when it comes to comparing the five year course with the six year course. I think some of us with fair experience of teaching have found it difficult to determine any improvement in the product after six years over what we used to have after five years. I think probably the reason for that is that the student, being rather an astute person, adjusts himself automatically to the time that the academic leaders declare to be the correct time. He does just the same amount of work but takes six years.

2475. *Chairman*: Might it be that some things take longer to learn and take more effort to learn than others, or would you think it still right there should be the same length of training for all the branches of medicine?—That raises the question, does it not, of what we might call basic training of the doctor? I think my colleagues here would agree with me it would be most unwise to devise any medical curriculum which showed any tendency to specialise before graduation at a basic training level. In fact the development of the specialist physician and surgeon and gynaecologist comes after he has had his training and his year as house physician or house surgeon. Then he begins to show a trend for one or other specialty. Then he enters on a highly specialised course of training.

2476. *Mr. McIntosh*: Is it true there has been some move to make it possible for the Scots boy to start in what is

now the second year of medicine instead of the first? I think the Commission ought to know about that.—Yes. There has in fact been an attempt by the Scottish Universities virtually to imitate the English system and to permit a boy from a Scottish school or from any school, Scottish or English, to enter a Scottish University and present himself for the examinations of the first M.B. That of course is a pretty exacting test. It means he must have attained first year university standard while at school. As far as Glasgow is concerned he must pass in all three subjects he takes, otherwise he goes back and does the whole lot again.

2477. Does it not mean he merely stays on for a year beyond his leaving certificate at school and does his sixth year in Scottish schools? Is it not possible a fair number might not achieve that?—I hope it will turn out to be so. Sir, but technically I think it may well be dependent on the requirements of, say, the department of physics and chemistry in the University, which may be so exacting in terms of the kind of training that comes through special facilities that they might not be available at most schools. Therefore the boy may be a very able boy but may be at a disadvantage.

2478. *Sir David Hughes Parry*: I wonder if we could go on to our question V on page 464, the position and prospects of a newly qualified doctor. We all regard your answers 8, 9, 10 and 11 as very interesting and we would like to go into them. I think you would agree it is one of the most important matters we have been investigating.—I realise that and would like the Chairman's permission for Dr. Joseph Wright to deal with these questions.

2479. May I begin by drawing your attention to the statement you make in the middle of answer 8 that the young doctor's salary, after 6 years of training, is low compared to that in other professions. Now we are interested to know where you get the figures and evidence to compare it with other professions. What is the basis of comparison? That is what we are trying to get at.—*Dr. Wright*: I take no personal responsibility for this particular statement! Professor Alstead has asked me to extricate him from a difficulty (*laughter*) but the very simple answer is we have no exact

figures. Here we are dealing with impressions of the position of young folk coming out in other professions being better able to afford things than the young man graduating in medicine. There are no actuarial accounts we can present on each profession.

2480. You have not compared him for example with the lawyer, have you?—That would be a very difficult task—nor with the minister, nor with the school-master. We have—I think we must admit—no exact figures. We are giving a general impression which we hoped you would verify in the course of your investigation.

2481. *Chairman*: You know we are sending out questionnaires to many professions and hope to get this kind of information?—Yes.

2482. *Sir David Hughes Parry*: In the last sentence of answer 8 you say you consider "that the imposition of a compulsory charge for board and lodging in these circumstances is unjustifiable." I wonder why you say "in these circumstances"? Is it in comparison with the position as it was before the National Health Act?—No. We are merely dealing with a state of affairs where a young man is compelled to work for 24 hours in an establishment, that is, his working day is 24 hours, and he must lodge in that place. We would assume therefore that he must have food and lodging, that that should be provided by those who employ him on 24 hours work.

2483. Would you compare his position after 1948 with his position as it was before?—It depends. If I compare my own case I received very bad food, and no pay. Some time after that my pay was raised to £25, later to £50. I think it went up to £100, but I do not think the fact that we lived in a sort of Dickens situation in my day is any reason for imposing these conditions on young folk now. They are much better off than in my time; there is no question about that. We still feel if you are going to ask a man to be 24 hours on duty he should expect his food when he is there.

2484. But some allowance ought to be made, some recognition other than the rate of remuneration?—He can have an allowance. There is an allowance made, but we think it is inadequate and that he would come off better if he had a set salary with this removed.

2485. *Sir Hugh Watson*: The allowance was in fact agreed by the Whitley Council. You know that?—Yes.

Sir Hugh Watson: It is an agreed figure.

2486. *Sir David Hughes Parry*: And as it is an agreed figure for income tax purposes, it may be to the advantage of the young man.—I think Mr. Robert Wright will deal with that.—*Mr. Wright*: The grievance I think the junior house officer has is this: firstly, he is compelled to live in; secondly, he has a compulsory stoppage from his salary—a stoppage which is taxed for these facilities which are not uniform. Furthermore if he goes on holiday the stoppage persists. It is also charged on his locum who shares the same room. These are felt to be distinct grievances by these young men.

2487. Do you think it is a fair ground for a grievance?—I think it is not an unfair ground. I think it would be much fairer if the position was that they received a salary as we did in the old days plus their board and lodging and no bookkeeper's figure was put against their salary to pay for this board and lodging.

2488. For income tax purposes some recognition would have to be made, would it not?—It was not in the old days—because we did not qualify for income tax I suppose.

2489. *Chairman*: Were the conditions pretty well uniform in what you got as a junior house officer, regardless of whether you were in a teaching hospital, or not? Now the conditions are uniform whatever kind of hospital he may be in; in the old days that was not so.—In the old days in the peripheral hospital one was liable to be better off as regards remuneration.

2490. Do you think it was better that way or better to have the uniformity?—I think under the existing system of pre-registration, and a compulsory year's service in a hospital it is essential there should be uniformity.

2491. But that does lead to a great deal of competition for some, and less than none at all for others?—Yes, but I think it is in the best interests there should be competition for the best posts.

2492. *Professor Jewkes*: You have just added one minor point. Is it true in the case of these hospital people that they

have to continue to pay for board and lodgings even when they are not there?—That is so.

2493. *Chairman*: It is an annual charge agreed by Whitley Council. An annual charge probably takes account of the fact the man is away for a certain amount of holiday each year. That is presumably allowed for?—Presumably so.

2494. If that is so that takes away the sting of that criticism.—Except that the locum has to pay the charge.

2495. *Professor Jewkes*: Has no protest been made to the Whitley Council about that?—*Dr. Wright*: It seems to be a curiously local thought because as far as I know, as a member of one of the Edinburgh Colleges there is no support from house physicians or house surgeons on that point.

Sir Hugh Watson: The point was taken by the Edinburgh colleges too.

Mr. Bonham Carter: I think it is a question which also arises right outside the profession.

2496. *Sir David Hughes Parry*: It applies also in the case of teachers at a university who have to reside in. The same problem arises, but I think the figure of payment is perhaps lower than it might be if the sum were paid outside. Now I wonder if we can take you to a most important answer on No. 9? You refer to the rigidity of the present system whereby there are different avenues for the young practitioner to proceed along. You refer to the rigidity of the present system which imposes this choice of a career at such an early stage. I wonder if you will describe what you mean by this rigidity? What is behind it? Why is it a rigid system?—I think one can best answer that by going back to what did happen before. A young man after qualification, if he was particularly bright, would probably become attached to a University unit and go straight on with a consultant post or professorial post in the future. Others would be appointed having in mind the possibility of going into general practice, continuing in hospital or, after continuing in hospital for a time, moving out into general practice, staying there or coming back. I worked as a general practitioner in panel practice. After some years I carried on a West End practice. I came back to hospital. I taught in the hospital

and did my West End practice. Then when I received an appointment I went into consultant work. There was very considerable elasticity in my time. It would be almost impossible for me if I were in general practice now to get back into a consultant post in any hospital, and it is exceedingly difficult, after ten years in a teaching hospital, to get into general practice with any hope of a senior post in general practice at a comparatively early date. Once a man goes into hospital he is at a disadvantage as far as general practice is concerned. Once he goes into general practice he has a tremendous disadvantage as far as hospital work is concerned. That was not altogether the case prior to 1948.

2497. Now can I ask a direct question? Whose fault is it that matters are so rigid now? This is a very important matter.—Not mine, Sir. I suppose one could say that it is the fault of those who planned the scheme thinking that we could have a group of officers in hospital and privates outside.

2498. I think you refer to this particularly in the matter of vacancies. Who declares in the first instance whether there are vacancies in general practice?—This arises in several ways. I have been out of general practice for some time but one of the ordinary ways is for a senior general practitioner to decide the time has come when he might consider having an assistant. He will then take on an assistant and, if he is successful and the practice continues to flourish, then he will apply for a partner, likely to be that assistant. A vacancy may arise through retirement or death, when the local Executive Council will make the appointment. The Council will pick a short list from the applications they receive and interview these.

2499. *Chairman*: Who are the interviewers?—Again I must go back to memory. I can say they consist of medical people themselves and lay members of the Executive Council, mostly the general practitioners of the district.

2500. We cannot help feeling that the profession itself bears a good deal of responsibility for this rigidity. Is that fair?—I would say that is absolutely fair, yes.

Chairman: Before we can do anything you will realise we must get to the

bottom of the problem of the responsibility.

2501. *Professor Jewkes*: Are there any technical reasons for increased rigidity? Is it possible that the increasing specialisation in itself makes it more difficulty for this switch to be made? Is it the change in medicine itself?—A great deal of medicine is becoming more and more specialised. The young man is at an earlier date becoming trained on special lines and therefore he is tending to lose a little of his general training. I think prejudice plays a part as well.

2502. I would accept that as a part answer. There may be something in the attitude of the Executive Councils. Take the doctor who has been in a hospital for several years. General practice is a skilled occupation of its own and therefore a move from hospital to general practice would put the man at some disadvantage?—No, Sir, he should make a good general practitioner. As a hospital worker I think he has got training which will make him fit general practice better.

2503. *Chairman*: At some stage in their career they have got to decide what line they intend to follow. They may find it wrong and later on want to change. That is another matter, but they must decide at some stage, at some age, what sort of thing they are going to do. In this particular sphere it is really mainly whether they are going into the hospital service or into general practice. There are other things, but these are the two big branches. I think you say they have to choose a little bit too early and consequently, having chosen it, ought to be assured of switching to the other one within the next two or three years without much difficulty?—That is correct, Sir.

2504. You say they have to make the choice now normally at about 25 or so?—No, they have to make the choice when they come back from Army service. They may make one of two choices. They may decide their bent is general practice, that they are going to obtain an assistant post or will apply for a post as an assistant with a view. They may decide to have a short spell in fever or maternity, to fit themselves for general practice. That young man is in tremendous difficulty.

2505. But the age at the present time I think is not as early as 25 because of National Service. It might be 27. What age do you think he ought to be facing this main decision?—I think that is one group I am dealing with. There is the other group who have ambitions for hospital but are prepared to go into general practice. If they find they are interested once they go into hospital and are there for two years, it becomes exceedingly difficult for them to get out into practice again.

2506. I want to take it in two stages if I can. The first stage is at what age do you think he ought to make up his mind as to the particular direction his career should take?—Taking the first stage I think that everybody should be entitled to one or two years seniority in one or other line before he decides for which of them he is better suited.

2507. You do not think the present age is too early an age for him to make up his mind?—He is old enough to make up his mind but the majority—a considerable number—of people will have a desire to get into hospital, and a teaching hospital, and they should be given an opportunity of going there without fear that they have closed the door to general practice after they go in.

2508. *Sir David Hughes Parry*: It is a question of time, not age then?—Yes.

Chairman: You want to feel sure that if they think there are better prospects or they are better suited to the other career they should be able to change over during the first two or three years? There would seem to be two main obstacles to that in theory. One is the rigidity of the system, the unwillingness of the Executive Councils to accept somebody who started on the other branch, and the other will be that the two branches were so different that one way or another you had a very big drop in income. I think you imply that second condition.

2509. *Sir David Hughes Parry*: Can I just ask, do you anticipate that if there is an increase in health centre practices and group practices, that the reluctance of the Executive Councils to employ persons who have been in hospital for two or three years would diminish?—I think that if the health centre, the real health centre, comes into being most doctors will be hospital-minded, and that that will reduce the difficulties of the

young man in hospital. That is a health centre with proper ancillary facilities.

2510. What about group practice, that also?—A group practice only if it has such facilities as to make it hospital-minded.

2511. *Chairman*: Such evidence as we have had on group practice has shown it does contain specialists within the practice.—That type would certainly tend to lessen difficulties.

2512. *Professor Jewkes*: In the meantime have you any suggestions as to how this resistance on the part of Executive Councils could be reduced?—One suggestion we did make—I take it we will be dealing with it later—was that instead of having junior posts in hospital full-time, that the young man in such a junior post might be offered a part-time appointment and that he could use his extra time according to his own bent. That is on research, or helping in practices at night, familiarising himself with the peculiarities of general practice and equipping himself for dealing with the difficulties of applying for a post.

2513. *Chairman*: That is not the junior house officer?—That is after registration.

2514. *Sir David Hughes Parry*: Would you agree with the general proposition it would be useful to have the hospital doctor for a year or two in general practice, and a very useful experience for the general practitioner to have spent two or three years in the hospital service?—I should, of course, having done both. I think that it is excellent experience for any consultant to go out into the patients' homes and see the difficulties of domestic medicine. I also think that it is invaluable for the general practitioner to have extra hospital training, particularly along lines of fever, skin, maternity work, and in the basic scientific investigations of medicine.

2515. So really, speaking theoretically, there is no reason why this prejudice should exist, or this rigidity?—Theoretically perhaps not, but the introduction of a system which means full-time hospital appointments for junior men throws theory out altogether. These boys become hospital workers, and full-time hospital workers. They are regarded as consultant aspirants and when they apply for any job outside are not unnaturally regarded as consultant failures.

There is the prejudice on the part of the Executive Councils that they do not get applications from the best men.

2516. *Chairman*: If you were a general practitioner wanting to take on an assistant, you would yourself advertise for an assistant, and you would yourself look with favour at somebody who had done rather longer than the basic period in a hospital?—I do not think it is as easy as that. My son I would take on, my nephew or my friend's son. Perhaps fifth on the list would come the young man who had longer training in hospital.

2517. He would be fifth on the list. Would the sixth on the list be the person, no relation, who had just come straight out of hospital?—A fellow with hospital training certainly would, I think, receive points as against the man who had none.

2518. *Mr. Watson*: You would call that "family" rigidity?—Yes.

2519. Do you think that a salaried service would meet many of these objections you are now raising?—I think we have tried to deal with that already when we dealt with the question of full-time and part-time. My own inclinations are to argue that a little freedom, a little competition, a little selling of oneself, is an advantage to both myself and to other people.

2520. *Sir David Hughes Parry*: Could I ask this supplementary to Mr. Watson's question? What would your reaction be to a system whereby every young doctor was given a specific salary for two years after he has qualified? It would probably make for fluidity.—Again I would say that there would be a variable reaction amongst my colleagues. My own desire is of course that this young man should not be regarded as an infant who is to be given a salary, given a particular training and then put on to different types of work, but that he should be given the chance of doing something on his own while he is learning. I think there is a real danger that if he is given a specific salary and told it is for this and that, he will tend to do this and that. I am a strong believer in the young man being made to go and see for himself, for part of his time at least.

2521. But you see there are some of the young men who have better advantages than others. You want really to

give the same advantage all round, do you not, for the good of the service?—I do not think that is possible really. There will always be someone better than others. One has to accept that?—*Professor Alstead*: May I make a comment, Sir? We have heard the phrase "resistance" of the Executive Council to a doctor who has had several years in hospital, but it is only fair to say that one other factor is the large number of applicants for a vacancy in general practice. In fact only one out of perhaps 50 or 60 applicants can be appointed to the vacancy.

2522. *Chairman*: And actually only one sixth of the people that enter general practice enter in that way?—In that particular way, yes. If I may add another point—one phrase used in the discussion was the indecision as it were of the young men; but there again I think one must take into account the changing circumstances in relation to prospects in a period of three years. A young man may enter feeling there is a reasonable prospect of his going to this or that specialty. Within three years he may see the prospects are poor or, what is more likely, by the closer contacts with the specialty he may feel he is not altogether suited to it.

Professor Jewkes: I suppose it is true to say since we are examining all the points on this question, that the rigidity is in part explained in that a young man can no longer buy a practice where he might have done so before 1948.

2523. *Mr. Gunlake*: Professor Alstead, we have been told in other evidence, that in the old days the relationship between specialists and general practitioners was more effective. Do you think these barriers you are referring to, which prevent freedom of passage between one branch and the other, have anything to do with any deterioration in this relationship, and if so which is cause and which is effect?—I am not sure that there is less cordial relationship between the general practitioner and the specialist in private practice. Certainly as far as hospital practice is concerned—I myself am a hospital physician—I have not noticed any change in the attitude between the general practitioner and the hospital consultant. Dr. Wright may wish to comment, Sir, on what he finds in private practice, but I think one factor here which must be taken into account is the larger volume of work devolving

upon the general practitioner and in consequence a larger amount of work also involved in the hospitals and consultant capacity, and doubtless upon consultants who are engaged in private practice. To that extent if they are in fact over-worked perhaps the social contacts may suffer to some extent.

2524. *Sir David Hughes Parry*: Now you have suggested one method of improvement, that is to try and encourage more private practice at the early stage?—Yes.

2525. Have you any other method, any other suggestion to make? After all we are considering our main terms of reference concerning remuneration particularly from this angle—*Dr. Wright*: I think if we are allowing an escape route from the hospitals we should try in some way to make some re-entry route for those in general practice who attain a sufficiently high level of academic training. I should hope there would be less rigidity in the appointments for general practitioners in hospitals compared with the intermediate training levels.

2526. Now can we take paragraph 11 in which you say that the salary of a Junior Hospital Officer after registration should be raised to a level comparable to that of a trainee assistant in general practice. Would you explain what category of officer you have in mind there?—Yes. The junior house officer, then next the senior house officer who is below the registrar. There are two junior hospital officers. There is the house officer, the senior house officer and then the registrar.

2527. What is the present range?—*Mr. Wright*: For junior house officer the salary in the first year, which is a compulsory year, is £467 10s. for the first six months, £522 10s. for the second six months and £577 10s. for any succeeding period of six months.

2528. *Chairman*: I thought Dr. Wright was saying that what you meant here was the salary after registration should be raised, dealing either with the senior house officer or the beginning of the registrar stage?—No, Sir. What we are trying to suggest here is some means of holding back the entry into general practice of the young man who chooses such a career until he has had an opportunity to widen his experience beyond the compulsory year. At the moment he does six months' medicine,

six months' surgery. We would like him to be able to do six months in a specialty before he goes into general practice. At the moment the temptation is to do one year, then get out and get into general practice as quickly as possible.

2529. I think we have been told that there has been a considerably marked tendency for more people to take a second year's study. Would you know whether that is true?—It is difficult to believe this at the moment because one reason for the tendency I have mentioned is to do with the call up. Normally as soon as a boy has done his year he is called up to the Services and the only way of delaying call up is to try and get another job. If he gets a job for instance in maternity work he may be fortunate in getting a job as a trainee specialist and get a higher rank and a higher rate of pay in the Services. I have not noticed any tendency after military service for a young man to want to come back into hospital, because they suffer a considerable drop in salary. They want to go from the Forces and get straight into general practice which they hope will be better paid than hospital work.

2530. Are you suggesting the senior house officer should not reach those stages until a later age; that there should be a further year before his choice is made?—I think so, Sir.

2531. You would want them to come early?—As in fact they do now. He comes to his job three years after qualification; one year pre-registration and two years in the Services. He is very lucky if then he gets a senior house officer's job straight away; he may have to be junior for six months or so.

2532. Roughly speaking, the trainee assistant is about the same age as the senior house officer?—Yes.

2533. The figures are roughly equal, but you are suggesting something different?—That is right, yes. What we are suggesting is before the man becomes a trainee in general practice, by whatever route, he should have a broader based hospital training than he now has or tends to have by being encouraged to stay on in hospital.

2534. *Sir David Hughes Parry*: Does not the fact that there is difficulty in getting into general practice in effect force him to take a year or more of

hospital work? What does he do? Does he not take a hospital appointment?—He usually tries to take a trainee appointment in general practice, which is an assistantship without any possibility of a future. It is a year's work and then he must move on. He has committed himself. He has passed on to being a trainee in general practice without having a broader based hospital training.

2535. Only a comparatively small number become trainee assistants, do they not?—A comparatively small number, yes.

2536. I have the impression that a substantial number of those who qualify and ultimately go to general practice are, because of the difficulty of entering general practice, in effect forced for a year or two to take hospital appointments. Is that a wrong impression?—It is not my impression.

2537. Not even in the slightly more advanced stages—registrars and senior registrars?—Certainly not. There is one point on the question of registrars and senior registrars getting into general practice. We must say that in Western Scotland the Executive Councils have been at pains to give places to the hospital services in short lists and indeed the usual practice has been to draw up a short list of six: two who are principals in practice; two who have been assistants in practice; and two who have been in the hospital service; and the result has been, of course, that someone from general practice has got the vacancy.—*Dr. Wright*: Could I amplify this question and tell you that there has been an attempt recently to institute a combined general practice and hospital appointment. That is a post advertised as a trainee general practitioner post with hospital attachment, and I think two such have been advertised in the west of Scotland. I do not think either has been filled yet because the young man who wants to go into practice goes for a full trainee course. The young man who wants to go to hospital goes for a full hospital course. The attempt to bridge in that way is not a great success so far.

2538. Is it proving unsuccessful because students are too shortsighted to want it or because they fear that if they take this training they will not get an opportunity of getting on?—I think it is the feeling of falling between two

stools. If they are going to be part-time in hospital they cannot compete with the whole-time man in papers, research work, and higher degrees, and therefore are already doomed to failure. On the other hand they are a year behind the man who has taken his general practice training which is regarded as of absolute importance.

2539. Does this really mean that so far the hospital authorities on the one hand and the general practitioner authorities on the other do not really quite share your view that it is an advantage to take a longer training period before going on one side or the other?—I have the impression that if such a young man gets this appointment he should be regarded as having done something which would guarantee him extra points when any subsequent appointment is being considered. Some firm arrangement should be made that this is to be regarded as a better form of training and that Executive Councils will consider such a man favourably. Otherwise he will be very foolish to take it. I think it is the absence of any assurance that this type of appointment will account for anything that has led to its failure. I am quite certain that unless there is a definite statement made that this type of training will be considered favourably, it will continue to fail.

2540. This is a matter for the profession to try and settle?—I would say it is a matter for the Executive Councils.

2541. Would the hospital trained person have an advantage?—We are prepared to accept them and give them an opportunity. I do not know where there could be any guarantee that they would have an advantage, because in terms of hospital practice they are already starting at a disadvantage; one must be quite clear on that. It is a question of getting them to believe that hospital training is an advantage in general practice.

2542. On question VI—any trend to excessive resort to certain branches of the profession at the cost of others; you say in your answer 12 that in several specialties the shortage is already a serious problem. Why should the young men tend to prefer the wider fields?—I do not think there has been any great change in the trend away from the

narrower specialties; there never was a trend towards them. There is an increasing need for certain specialties, an increasing need for certain minor specialties, such as radiologists. Prior to 1948 it was exceedingly difficult to get a radiologist in a teaching hospital. We applied for a radiologist at that time, and I think we had only one or two applicants. The trend has always been towards the major branches of medicine and surgery; there is an increasing need for these other specialties, and therefore a recognition that they are not so attractive as the main branches.

2543. Would a radiologist post be much more difficult for somebody to get as a half-time post than those in other branches?—Yes. I think firstly there is the attraction of the major branches. The young fellow coming into hospital wants to be a physician, a surgeon, a gynaecologist; and then there is the odd one who feels his bent is physics and radiology and is so attracted. But there are very few who start off desiring to go into these other branches—very few who go in for the full-time type of appointment.

2544. You have experienced this in the Faculty? You have a responsibility as a professor to try to influence people into branches where there is greatest need, if they have a particular aptitude.—*Professor Alstead*: Yes, Sir. I think if a student does in fact display some interest in basic sciences while he is pursuing a medical course there is an obligation on his teacher to point out to him that when he has graduated he should perhaps take full advantage of these special aptitudes. But in general the medical students are recruited because of their interest in the practice of medicine as a clinical science and not because they are particularly proficient in the basic sciences, chemistry and physics.

2545. Is there anything in the suggestion that these particular specialties do not offer as many opportunities for private practice as the major branches?—I should have thought they were at least equal.—*Dr. Wright*: I think a young man wanting a part-time job finds that the major specialties are the most attractive. The radiologist doing full-time would compare very favourably with pretty well any branch; but where a part-time post is wanted it is one of

the major branches which he would find most attractive.

2546. Is the indication of your reply that those in the particular specialties ought to be better remunerated than those in the general specialties?—It is a very difficult problem. In training our young man, if a young fellow is showing signs of feeling the competition in one line of medicine, I do suggest that he might look around and see if there is something he might be better employed doing, both in terms of his inability to face that competition and his own desire to seek a new line. It is very difficult to get any of them to move off from the line of medicine. One of them has gone into psychiatry; but I cannot get any of them to do radiology, even with the bribery of a suggestion of a definite appointment.

2547. What alarms me is the statement you make in paragraph 14 that competition is not sufficient to maintain the desirable standards.—*Mr. Wright*: It is not really apropos these rather narrow specialties. From their clinical magnitude it is quite evident they attract a very special type of medical people. No matter how big the carrot you dangle you will only continue to attract this type of people. I do not think that remuneration has a great part to play in any trend to or from these very narrow and highly specialised branches. The last paragraph here is apropos the recently developing situation in regard to the major branches. There has been quite recognisably a falling off in the number of applications for registrarships, even in the major specialties, general surgery and general medicine—that is our worry. It is quite clear the young men are not coming forward.

2548. *Sir Hugh Watson*: Why do you think that is?—Because of all the talk among their friends—those who are on the ladder as registrars and senior registrars, who are stuck there.

2549. *Chairman*: Coming back to the narrow specialties you mention in your answer 12, I expect you have seen the Ministries' factual memorandum. I do not find any common pattern there as between part-time work and full-time work. Of these particular specialties, radiology, radiotherapy and mental illness have far more than the average proportion of whole-timers; on the other hand E.N.T. and ophthalmology have far less, and a very big proportion in

private practice. There does not seem to be any particular significance in this.—The horizon of the ophthalmologist is a narrow horizon; it does not appeal to the average young man who takes up medicine as a career and has a vocation to treat patients. I think it is as simple as that.

2550. And there is nothing you think we should do about that?—I do not think there is.

2551. *Sir David Hughes Parry*: In paragraph 16 of your answer you suggest in your second sentence that "the value of this position [the opportunity of choosing between whole-time and part-time service] lies in the fact that it allows a consultant to choose the form of service which suits his own particular temperament, and gives the patient a freedom of choice of specialists which would otherwise be unobtainable." Who have you in mind as having freedom of choice there?—The patient who chooses a part-time specialist has clearly a wider field of choice than the patient who chooses a whole-time specialist. The whole-time consultant draws his clinical population from the population that his hospital serves, via the general practitioners.

2552. The choice of specialist lies with the general practitioners, not the patients? I read what you say to mean that the patient who is a private patient has certainly freedom of choice, but I thought you might also mean a person attending hospital under the National Health Service, and not under private arrangements. I am not quite certain which is meant.—*Dr. Wright*: Both. the answer that the medical man chooses the consultant at all times is not truly accurate. The patient or the patient's relatives not infrequently suggest to the doctor that they would like Dr. or Mr. So-and-so to see him, and that does happen in private practice. They have freedom of choice of a particular person. Prior to the scheme the person who could not afford a consultant might get one if the consultant happened to be in the district and was brought in to see the patient for nothing, but they had not much choice in getting one. They now have the right to have a consultant for whom the country will pay.

Sir David Hughes Parry: It is not a very big freedom of choice it is very limited.

2553. *Professor Jewkes*: In the case of a patient under the National Health Service, how much freedom of choice does he get?—He has a consultant to see him which he might not have had before. But freedom of choice in terms of the individual will depend on the district where he is.

2554. The private patient has an extended freedom of choice?—Yes.

2555. *Mr. Watson*: Is it strictly correct to say that a patient under the Health Service can really choose a consultant without cost to himself?—Unless there is something really wrong.

2556. *Chairman*: He can choose his consultant?—No, he can ask his doctor. The choice is the choice of the doctor.

2557. *Mr. Watson*: I think I had better repeat the question. I think there may be some misunderstanding. Is it strictly correct that a private patient under the National Health Service can choose his specialist without cost to himself?—No, a private patient will ask to see a particular consultant, either privately, or his doctor may decide he wants a particular consultant to see him under the National Health Service.

2558. *Chairman*: But not without cost to himself; he has to pay if he is a private patient.—A private patient will have to pay.

2559. *Sir Hugh Watson*: I am not quite sure that Mr. Watson has got his question clear. I think what he wants to know is can a patient under the National Health Service through his medical practitioner employ a particular consultant without cost?—The answer is yes and no. Let me try to explain. Let us say he is in Ayrshire where there are only one or two consultants and he says to his doctor: "I want a medical consultant," and the doctor agrees he needs a medical consultant. There may only be Doctor A there, so he is having complete freedom of choice of the available consultants. If on the other hand he says: "I want a consultant from Edinburgh to come and see me," then he is asking for a private arrangement for this consultant to come and see him; and his doctor is entitled to say: "this man is part-time; he will come in his own time to see you at your expense."

2560. Supposing the patient is in Edinburgh and requires a consultant in any

of the specialties you have mentioned. If he says to his general practitioner: "Can I see Mr. X?"—That would depend on what Mr. X's condition was, would it not?—Do you mean high or low?

2561. Whether he was part-time or whole-time consultant.—If he is part-time and the doctor thinks his patient needs a consultant under the National Health Service, then the doctor can say: "Yes, I want him to come, and also I will arrange for him to come for a domiciliary consultation at no cost to you."

2562. *Sir David Hughes Parry*: In paragraph 16 you say that "One of the better features of the National Health Service is that the conditions allow the consultant to practise either whole-time or part-time. The value of this position lies in the fact that it allows a consultant to choose the form of service which suits his own particular temperament and gives the patient a freedom of choice . . ." What in fact you are saying is it gives the patient of the general practitioner a limited freedom of choice; is that right? You do not refer to the fact that the part-timer has a better aggregate remuneration at the end of it. That would be so, would it not? He is economically better off?—*Mr. Wright*: It depends on the circumstances, and on the time.

2563. He receives remuneration on the basis of nine and a half sessions if he is doing nine sessions. He gets better income tax allowances; is that right?—Yes, if he is part-time.

2564. So that there is a tendency towards higher remuneration for the part-timer?—Provided he has nine sessions. But if he has only seven sessions then when he starts off in consultant practice he has a great deal of initial expense; he has teething trouble and it may take him many years to build up a sufficient private practice to compensate for those expenses.

2565. He does ultimately do it?—He should, he hopes to do it.

2566. And he will get better allowances for tax?—Yes, he will get better allowances in regard to his motor car and his telephone and such things as membership of scientific societies, the taking of journals, and so on. His only advantage is in regard to allowances. Perhaps there is some slight advantage

in allowances to offset against the income which he must necessarily make in order to be able to afford these things.

2567. I would like to get your opinion on the question of remuneration at the rate of nine and a half sessions for nine sessions.—*Dr. Wright*: My reaction is that I am never paid more than I work for, and the idea of the extra half session is to take into consideration the hours of responsibility in which one is away from the hospital.

2568. Those in full-time appointments are paid on the basis of eleven sessions.—They are not really full-time. I think this is surely an erroneous concept. The full-timer does domiciliary visits. If he is full-time how can he be paid in the service for something he does within his full-time? He can still do up to 232 domiciliary visits and be paid for 200.

2569. *Professor Jewkes*: You do in fact suggest in paragraph 20 (5) that the difficulty associated with the first eight visits in each quarter should be removed.—I do not know; my own personal feeling is that we should think in terms of eleven sessions and nine sessions, and not in terms of full-time and part-time. The man who is worst off is the man who is full-time who is doing no domiciliary visits at all.—*Mr. Wright*: The reason we made that comment about domiciliary visits is that there are many whole-time officers called upon to do domiciliary visits and who do not in fact do as many as eight, and they get paid nothing. We feel if the eight have to be deducted they should be deducted at the other end, after the 200.

2570. *Chairman*: I think I see the point. It is certainly true that in some specialties you can do domiciliary visits and in some others you cannot. Therefore the man with 11/11ths in some specialties may be limited to 11/11ths plus nothing?—*Dr. Wright*: I think that is so. I think there are real full-time workers and others, and they should be considered separately.

2571. That is quite in accordance with the general position you take up that all specialties are equal in status?—Yes.

2572. *Sir David Hughes Parry*: In paragraph 19 of your evidence you say you consider it a serious disadvantage that, at least in Scotland, all training

posts are full-time. Which training posts have you particularly in mind?—What was in mind was the senior registrar.

2573. Nothing below that?—I personally would go further, though this is a thing on which there is some difference of opinion. I would like to see both registrars and senior registrars in part-time appointments.

2574. Could you indicate the reasons why?—I think a young man in hospital should have the opportunity of showing his own worth—that is, he should be appointed for so many sessions to the particular job, and then he should look around for something to make up his sessions which he feels he wants to do. He should have the opportunity of applying for a post in anatomy, physiology or pathology in the hospital, applying for a research grant for this purpose, if he so desires, or going into general practice, assisting, if he feels that is the line he wants, doing medical boards, doing some consultant work if he can get it; but he should have the opportunity for part of his time to show that he can do something on his own, something he has a desire to do.

2575. This would place a good deal of responsibility on organisation—someone to see that he gets a part-time post, and that sort of thing?—I think it would only throw responsibility on himself, because if he is doing seven or eight sessions at hospital then the responsibility is on his seniors only to that extent. If he is doing research work in his own time then the responsibility is his own in producing results; if he is outside the hospital then his future success will depend on him.

2576. You would have his part-time registrar work on sessions?—Yes.

2577. *Professor Jewkes*: Would you go as far as to allow the senior registrar to do domiciliary visits?—Yes.—*Professor Alstead*: I think Dr. Wright has emphasised the offering of the opportunity rather than the insistence on the opportunity being taken. Therefore I imagine Dr. Wright's suggestion would not carry with it the need for any supervision or any increase in pay. It would in fact be the same salary, but within the job there would be more variety available.

2578. *Chairman*: If the senior registrar were making domiciliary visits he would not have any opportunity to start in general practice?—No, he would be on the same footing as the consultants in relation to general practitioners.

2579. Have you any views as to how the general practitioners would welcome that, whether they would take advantage of the opportunity to seek a visit by the registrar or senior registrar?—*Dr. Wright*: One can only speak from past experience. At that age I was doing extra work of the laboratory type of consultant practice which the senior registrar is quite capable of doing. Nowadays, for instance, the man at that level would be much better dealing with the problems of transfusion than his senior colleagues, dealing with blood sugars and things like that; these are things as a young fellow one made a living at before getting to become a consultant.

2580. *Sir David Hughes Parry*: I am not sure I understand you accurately. Your suggestion is that he would be paid for so many sessions, and then he would earn his living in his free time in his own way?—Yes.

2581. This might add a good deal to the insecurity of the registrar's position if it became general.—I think Professor Alstead made the point that that again would depend on the bent of the young man; one man might want full-time in hospital up to consultant level, or the other one might like to try this or that.

2582. Would you not consider that although this might be for the good of the young man it might not necessarily be for the good of the National Health Service?—I think it would be to the benefit of the Service if the young man was allowed to develop untrammelled by his seniors.—*Professor Alstead*: It seems to me this kind of thing is happening already in the sense that a registrar or senior registrar may quite legitimately devote part of his time to research, which he designs and carries out within the time that he is in hospital. It is in fact part of his clinical duties; he puts in extra time in order to supplement his experience, and to gather material for a thesis. So in principle it would appear this kind of thing is already going on.

2583. *Chairman*: He is now a full-time but unestablished hospital employee?—That is so.

2584. Do you know whether the Hospital Boards themselves would be keen to take on senior registrars part-time instead of full-time? On the other hand, would not the senior registrars have a special problem in return, because they would be getting less money from the hospital? Perhaps they would regard that as an advantage because it gave them a better way out into other jobs or up to becoming fully qualified.—I think that many senior registrars who had decided quite firmly to stay the course and try to become consultants would, at one stage of their training as senior registrars, welcome the opportunity to go out into the homes of patients and see patients with general practitioners, in order to get a first-hand impression of the kind of work they were in fact being committed to in their career. This kind of thing happened before the National Health Service began when relatively junior men taking out-patient sessions became known as competent young men to general practitioners whom they served very well through the out-patients departments. The general practitioner did send occasional patients to them or invited them to see patients privately in the patients' homes. That kind of thing was happening, not to a great extent, but it did happen.

2585. *Sir David Hughes Parry*: To come back to your answers; in subparagraph (4) of paragraph 20, what do you mean when you say that some whole-time consultants feel it a grievance that they receive no extra payment from the University for clinical teaching?—*Mr. Wright*: This happens in my unit, where I am part-time and my two assistants are both full time. The University method of payment is to pay a certain sum to the chief of the unit and lesser sums to the two assistants, provided they are part-time; if they are whole-time they do not qualify for any additional payment for teaching.

2586. How do you determine whether they are part-time or full-time?—Under their contract with the Regional Board they are either full-time or part-time.

2587. And do they enter into that agreement voluntarily?—They do.

2588. They cannot have it both ways, can they?—No; we have put this point for them out of a sense of duty.

They do feel that this is a very real grievance.

Sir David Hughes Parry: If they have really entered into a contract, that is the end of it, is it not?

2589. *Sir Hugh Watson:* If they want to enter into any contract at all, that is the only contract which is open to them?—It is the only one, yes. They have no choice in the matter. If they want to keep their hospital status and they want to participate in teaching, they have to do it under this contract.

2590. *Chairman:* There is another factor to consider. If they did not do any teaching they would be much less likely to attract attention. As it is, they have the possibility of getting extra salary in the shape of a merit award.—Definitely.

2591. So there is some compensation for keeping yourself up to date?—There is.

2592. *Mr. Watson:* Is the opinion that is expressed in here, in paragraph 20 (5) the opinion of the Faculty or the opinion of the author? It says: "There is a large measure of agreement from all sources that certain anomalies and disadvantages exist under the terms of service and these appear to be largely financial and related to Income Tax regulations." Is that the opinion of the Faculty or the author?—It is the opinion of the Faculty.

2593. *Sir David Hughes Parry:* You must be very well aware of the difficulties in this respect: you must realise that these regulations are administered and given effect to by the Board of Inland Revenue.—That is recognised.

2594. And in respect of allowances doctors cannot get better treatment than members of other professions?—I think that is too harsh. I think this claim is based on the recommendations of the Commission that investigated Income Tax. They did suggest that a more realistic attitude towards whole-time personnel might resolve all the difficulties.

Sir Hugh Watson: This matter is under discussion with the Inland Revenue authorities at high level now.

2595. *Sir David Hughes Parry:* We are very well aware of the problem, but on the other hand we have to realise this is the position as regards other professions.—Yes, we do realise that.

2596. And we recognise also there may be a slight difference in administration. In paragraph 24 of your memorandum you make an interesting suggestion as regards an intermediate grade of specialist.—*Professor Alstead:* Yes.

2597. Would you explain what you have in mind and the type of person you think the situation would call for.—*Mr. Wright:* What we have in mind is not to suggest a new state of affairs, but to suggest a just resolution of an existing state of affairs; the state of affairs being, in short, that in the service there are now very large numbers of senior registrars who have served long beyond their anticipated period of training, who are now in effect doing highly specialised work, but who are still being paid as senior registrars. They have no hope of further advancement until consultant posts become available. A scrutiny of the possible availability of these posts shows that to many of them this hope is still 10 or 15 years off. We feel, because the service needs these people, because it needs the quality of the work which they give and are giving, that they deserve to be—if they must be put in a category—put in a category other than senior registrar, which makes out that they are still in training, when in fact they are trained. We feel this fact that their training has been completed should be recognised, and that they should be paid as specialists, if it is in fact impossible that they should all be paid as consultants.

2598. Do you anticipate there may be a percentage of these men who really will never become consultants?—Yes, I do.

2599. Could you indicate what proportion?—I do not think it is possible to give a proportion, because the competition for consultant posts is now so keen that among the applicants will always be found some time-expired senior registrar competing with some exceptionally bright senior registrar. Therefore the time-expired senior registrar may well fail to get the post; and this may go on and on, and in that event he may never become a consultant.

2600. You would expect an advancement, an annual advancement or a two yearly advancement in salary—for that period of time?—It is suggested that they come in on a scale of salary which

will bring them up to something short of the starting level for consultants, and might even go further up. We feel that the advantages of this are, first, that the service is not deprived of these specialists, and secondly that there is a continuing availability to the service of the best possible people.

2601. You know there is a fear in some quarters that if this is done it might be regarded as a watering down of consultant status by allowing other people to do consultant work?—We have asked that that be safeguarded by saying that the first prerequisite of this scheme should be a proper evaluation of the consultant needs of the service. Then the medical staff of the service should be acquainted with what the employing authorities consider to be a proper consultant establishment—a thing which we have never yet been told.

2602. *Chairman*: You realise this would always be a changing figure?—It is bound to be a changing figure.

2603. In some areas it will be going up and in some going down?—Yes.

2604. It is difficult to establish a figure which would give cover to the profession itself, which is what matters.—It does not seem to me personally that there is any need to establish a firm figure. In the Army, for instance, the Army Council have an establishments committee. The specialties of the Army vary from year to year, just as in the National Health Service, and it does not seem to present any problem there.

2605. *Str Hugh Watson*: The Army has been going on a very long time, and all this medical service is new. This is part of the teething troubles; and you would agree that one of the things which is causing this had block of senior registrars at the moment is the considerable influx of registrars between 1946 and 1952?—Yes, we would agree.

2606. To some extent there is a special situation just now, which will pass.—Yes; it will not pass in Scotland for some 15 or more years. There are two complicating factors; one is this big increase of trainees in 1946-1947. The other is the big influx of consultant appointments in 1948. Most consultants in Scotland have at least 15 years of service, if they survive, still to do. There are not going to be many consultant vacancies in these 15 years.

2607. There is a curious thing here. You are suggesting—some of the other Scottish Colleges are also suggesting—that in order to avoid the feeling of frustration that exists among these senior registrars and S.H.M.O.s, you should put in another intervening grade between them and the consultants. Your friends across the border take a diametrically opposite view; they think that would only aggravate the sense of frustration. What do you have to say about that?

—I would like to say, before Dr. Wright speaks, that this state of affairs already exists. These men are there doing this work; they are called senior registrars, but in effect they are employed as specialists. We feel the English attitude is unrealistic. We feel it is coloured by the fear of dilution of the consultant establishments, and we have asked that this be avoided by the insistence on the formation of an establishments committee to ensure that it does not happen.—*Dr. Wright*: If I could answer that by pointing out the difference in Scottish hospital medicine as contrasted with English? In England the consultant is a man in full charge of beds, wards or part of a ward, whereas we have worked on a tier system—a chief in charge of wards, with a tier system.

2608. A hierarchical system?—Yes. It is no new idea to us that there should be somebody of relative seniority and considerable experience still acting as an assistant. But that would be a new arrangement in England. Yet, curiously enough, it is the arrangement that they have introduced into their teaching hospitals in the professorial unit. I know of no professorial unit that runs with two professors. We think it is a natural arrangement to have heads and to have divisions and to have establishments, and to have these people feeling that they are in the establishment and that they are not to be thrown out this year or next year because their training is up.

2609. What these other bodies feel is that there is a danger that if a man is promoted to this grade which Mr. Wright mentions, in the expectation of later becoming a consultant, he will stick there, he will cease to be considered.—But if this is recognised as the next stage towards consultant, as it must be, then he will not stick there if the opportunity of promotion arises. Only if there was some curious arrangement by which

these people in training are guaranteed a consultant post, would this be a way of making them stick.—*Professor Alstead*: We are not in fact suggesting a change in the designations that exist at present; but rather to give due credit in financial terms to senior registrars who have, by experience and long service, qualified for salaries approaching to those of a consultant.

2610. *Chairman*: And security?—
And security.

2611. *Mr. Gunlake*: You would regard it as being of the essence of the contract in this kind of suggestion that there should be a fair establishment of consultants now and at all future times? You have no fear or anxiety that there would be any dilution of establishment in practice or that it would be unfairly settled—that is one of the fears in many minds.—*Mr. Wright*: It is a fear we would need to do our best to overcome.

2612. *Chairman*: Have you any idea how the establishment of consultants could be fixed?—I think it would involve a review of the work done and to be done in all the hospitals in the country.

2613. The review to be made by whom—by the Ministry?—I think it would probably be better done by neither party but by some independent body with some expert medical advice.

2614. It is a technical problem?—
Yes.

2615. You would agree that any solution of this kind is no good unless the profession as a whole are themselves satisfied that the consultant establishment is fair and is not being watered down?—Yes.

2616. *Mr. Gunlake*: Have any approaches been made to the Department of Health that such a review ought to be undertaken?—I do not believe any official approach has been made.

2617. *Professor Jewkes*: I do not understand why you do not agitate for more consultants in order to solve the question that way, instead of creating the additional grade which you mention. If, as you say, senior registrars are already doing consultants' work then those senior registrars are fully qualified to count themselves as consultants. Why do you not just agitate for more consultants and leave the senior registrar grade to serve the function it has served in the past?—There are two arguments against

that. In the past the grade has had no function in Scotland. The second is this; that if we go to the extreme of making all these people consultants, first, the chances of getting the Ministry to agree to any increase in consultant establishment seems very remote, and to get them to agree to this tremendous increase must be even more remote. We are not convinced that the ideal arrangement is a large number of consultants and a small number of trainees. If, for example, we make all existing senior registrars who are time expired into consultants, we are then left with a situation in which we will have a large number of consultants and a small number of registrars, with nothing between. There is a lot of work in many departments of the hospital which can best be done by someone between these two categories, just as in any other walk of life.

2618. *Chairman*: You consider that there is actually a place which ought to be filled by somebody at this level, somebody who is established—that is the important point? In terms of remuneration, you would say there is a place for someone between the ceiling of £1,540 for the senior registrar and the ceiling of £3,255 which is the consultant's?—Yes.

2619. Would you go a little further on this. At the moment do you consider that there is a serious under-establishment of consultants in Scotland, or is it only marginal?—I would say the shortage of consultants is only marginal—provided it is recognised that senior registrars are doing specialist work.

2620. I am talking of consultants.—I would say it was only marginal in Scotland.

2621. *Professor Jewkes*: I have one or two questions about this new grade. Would you conceive that all consultants would pass through this specialist grade—that no one should become a consultant unless he has been in this grade?—The occasional very bright boy would still become a consultant as he does now.

2622. *Sir David Hughes Parry*: You would contemplate that a person could still be appointed consultant who had not served his full time as registrar?—Certainly.

2623. *Professor Jewkes*: In other words you are not going to abolish the senior registrar grade?—No.

2624. *Sir David Hughes Parry*: You are proposing an extension of the senior registrar grade by an increased range of salary and establishment?—Yes.

2625. *Professor Jewkes*: And it would be a specialist group which would consist partly of people who were likely to become consultants, and partly of people whom it was felt were not going to go beyond specialist.—Yes.

2626. *Chairman*: Do you think there is a possibility or not of having a different system in Scotland from south of the border?—I do not think I am competent to answer that.

2627. Taking account of what Dr. Wright said, that you had this hierarchical system established here.—*Dr. Wright*: I think it would be highly dangerous to have this system in Scotland and not in England, because we do depend on export trade, and if a young man thought he would be put into a category that precluded his rising to a consultant appointment in England, he would be very hesitant to go there. This is really a repetition of what nearly happened in Scotland in 1952. The concept of junior consultant was introduced by the Department of Health. I think the decision was made for two reasons: firstly the weight of English opinion, and secondly the suggestions made by the Department of Health which did then make us feel that they were thinking only in terms of dilution and not of a proper establishment.

2628. *Sir David Hughes Parry*: In your paragraph 35 you deal with merit awards and you say in your first sentence: "While we have no suggestions for an alternative system, we feel that the method of allocation should be made more widely known." On other occasions I have suggested that there are three distinct matters involved here. Firstly, the criteria of awarding, secondly the actual method of awarding, and thirdly the nominating or naming of the person who shall receive the award. When you say the method of allocation you suggest that the names shall be published?—We do. I feel that secrecy always leads to suspicion. But the main difficulty is that probably the folk who advocate publication would

regret publication once it was passed. The whole purpose of secrecy now is to protect the man who has not received a merit award, and that has no weight in giving a full-time appointment. Its only value is on the commercial side of part-time medicine. I do not think if these publications were made in a medical journal that many patients would either see them or be influenced by them. There is, of course, the argument that doctors might see them, but the choice of consultants is for the most part not made on grounds of merit awards. I feel personally there is no tremendous danger in getting rid of secrecy.

2629. On the criteria; we were given to understand that the criteria are fairly well established and on the whole everyone is happy.—I do not know. I know what I would consider the criteria should be.—*Mr. Wright*: One is that a man has obtained a high position of respect in his profession by his good practical work. The other that he has obtained high academic standards for his research and teaching—an admixture of these of course would I think constitute the highest merit.

2630. These are generally recognised: have you any reason to think that these are not the criteria?—*Dr. Wright*: The unsuccessful man, I am quite sure, is certain that in his particular case they have not been taken into consideration. He can only argue in terms of his own case, because of the secrecy; he does not know.

2631. What about the method of awarding?—The method is one in which there should be fairly full discussion by those who have no particular axe to grind—those already outwith the range; and there should perhaps be an introduction of one or two lay persons to consider the evidence that is being offered.

2632. There is one lay person.—The method in Scotland is different from England, as perhaps you know; in the west of Scotland all merit awards are made after full discussion by all senior members of the profession, and these are agreed upon and put forward.

2633. Is there less unhappiness in that region than in other regions?—I think the answer is yes, undoubtedly; but again it is a terribly difficult question. At any rate there are less letters to the medical Press.

2634. *Chairman*: I think we were told that picking the As and Bs was relatively easy, but Cs were the trouble; the recipients of A and B awards were almost always leaders of the profession; that would be your experience in the west of Scotland too?—Yes, I think that is a fair comment. Our comment is that in the west of Scotland our university is deprived of the Cs that we should have.

2635. *Sir David Hughes Parry*: Could you explain more fully; I do not quite understand, I thought Universities had these Cs?—There is a division in regions, an arithmetical division, with two exceptions. There is weighting in favour of London; Oxford I cannot speak of particularly, but the two main university centres have an additional weighting.

2636. *Sir Hugh Watson*: We were told roughly speaking that there were 3,000 consultants in London and 3,700 outside, and that the awarding authority up to now has made it its policy to divide the awards equally between these two, London and the provinces; but Scotland is in quite a different situation. I would like to ask you one thing about Scotland. On this question of secrecy, we were told by Lord Moran in great detail of the anxious steps which he took to publicise among the profession the way in which he went about his task. Is anything like that done in Scotland?—Last year the Chairman of the Committee met the Consultants' Committee and described in great detail what happened, and roughly his description was this: that he himself took personal records in various part of the country, but in the main University regions there were senior people who took evidence and made recommendations. In the west of Scotland the senior person concerned called a meeting of all the consultants at higher level to seek advice, and then called meetings of all senior people to put forward the recommendations and discuss these in detail. From the west of Scotland there came an agreed recommendation, agreed by all the senior people, as to who should receive the awards of As, Bs and Cs. These went to the major committee, were argued, and then went on to London for acceptance or refusal. In Scotland there is, I think, a wider survey; there is more general agreement, and there is no question of any casting vote.

2637. We were also told that in England there was put before the committee a list which included every consultant who might have aspirations to any award at all, so that nobody was left out of consideration.—In Scotland I think the Department of Health have written to every consultant asking him each year to put in his curriculum vitae, and that is sent to the people concerned. They also have a list of all the consultants in the region, a list sub-divided into specialties. In our part of Scotland that sub-division is given to the senior member in terms of the merit awards for that specialty, which is for consideration, discussion and recommendation.

2638. *Chairman*: The total number of consultants in Scotland is something under a thousand—it is 800 or thereabout?—Yes, I think it is in that region.

2639. *Mr. Watson*: Has the Faculty any views on the merging of the merit award and the salary and giving it to the job and not to the man?—There are various views. One is that perhaps in the As and in the Cs that should be done; or that the Cs and Bs should be awards of responsibility and that the As should be left for distinction. It would sound in many ways an acceptable scheme. But I wonder if in the end it would be any more fair; because if the decision went to the appointments committees in the region, they are not necessarily in a better position to judge the particular merit than a group consisting of all the senior members. It also leaves the decision as to what is to constitute an important post; because that can vary very considerably during the lifetime of the individual who has it. He may make it important or unimportant.

2640. *Chairman*: Would it be easier to take the measure of responsibility? Could you define the responsibility of all major specialists?—It would make for tremendous difficulties; and it would mean that all peripheral appointments would be true responsibility posts.

2641. *Professor Jewkes*: Earlier on you said that personally you would have no objection if the present secrecy was removed; is that the view of the Faculty?—You would have a mixed bag of views. The view of our committee was that they would have no objection, but if you take various places in

the Faculty the opinion will change considerably as to what is the best method, whether it is good or indifferent; I think it is difficult to get a real consensus of opinion.

2642. *Sir David Hughes Parry*: The word "merit" is the trouble.—Quite right.

2643. It is really a method of recognition and better remuneration.—Yes. It is really meant to cover two things. It is the merit of the young man who does something brilliantly and the experience of the older man who does something, which attains respect. It is difficult to get a word that would evaluate that. I do not know what is the particular word for a variation in the degrees of merit.

2644. *Chairman*: If you would come back to the question of the specialist grade for a minute, your proposed new grade; I take it you are not proposing they would be eligible for the merit award?—I would think if they are they should be consultants, or would be pretty soon.

2645. That is what I thought. And if everybody becomes a consultant and has to pass through this grade, the age at which he becomes a consultant would be later, and the age at which he would be a brilliant young man would have to be a bit later.—Yes.

2646. That will be a problem.—The brilliant young man may still think of the possibility that he may jump this grade altogether.

2647. *Sir David Hughes Parry*: In your paragraph 40 you make an interesting suggestion in sub-paragraph (4), that registrars should be appointed to Regional establishments and all have the opportunity of working in both teaching and non-teaching hospitals—that is to meet the difficulties that the hospitals have in securing their services. Would you elaborate a little how you would propose that it should come about? It involves direction, does it not?—Yes and no. It must be apparent to you from your taking of evidence that the young man who goes to the peripheral hospital as a registrar has a much smaller chance of promotion than the man in a teaching hospital. I can speak from knowledge of that, having served on the Regional Board for quite a number of years. In England I think the chance of a man who is a registrar in a peripheral

hospital coming back to a London teaching hospital is nil. We feel if an appointment is made as registrar to a teaching hospital, with responsibility, for one year or six months there and another year or six months at the peripheral hospital, then it would be to the advantage of the registrar in terms of experience, to the advantage of the authorities making the appointments in terms of judging who were the best people for promotion, and that there would be nobody left out in the cold on the promotion rung. I think there is direction at the present time in that if there were two jobs available, A obtains the teaching hospital job and B the other one, and the one who is directed to the peripheral hospital has not very much chance against the other.

2648. *Chairman*: You limit it only to the registrar—you have not considered that principle might be applied further back?—It is the difficulty of that one year. I would like to see the Senior House Officer in the teaching hospital; I would like to see him replaced in the peripheral hospital by the registrar; I would think that would be a very much better arrangement.

2649. *Professor Jewkes*: How would that come about?—It could come about in Scotland without much difficulty by making all registrar appointments to teaching hospitals with attachment to peripheral hospitals.

2650. *Chairman*: Would this affect the senior registrar also?—I would think not necessarily. As I would visualise it, the senior registrar in his first two years would be better in the teaching hospital—once he gets to the grade we are talking about he would be in the teaching hospital.

2651. Could you tell me roughly what proportion of posts in teaching and peripheral hospitals there are for registrars?—That is in Scotland?

2652. I am talking about your part of Scotland.—In the west of Scotland the problem is not a big one in medicine or surgery; I would say in the teaching hospitals the registrars have about three to one at least.

2653. That would not be representative of the whole of England and Wales?—It would not be representative at all, because you are dealing with two entities there. It would mean a marriage

of two groups of Regional Boards and the teaching groups.—*Professor Alstead*: There is one minor amendment I should like to make to what Dr. Wright has said about registrars. That is perhaps the registrar who is attached to an academic full-time unit would need to stay in his position, because he holds his registrarship usually as a joint appointment between the Regional Board and the University. During his course of three years and sometimes four years in that appointment he is in fact being trained as a teacher, and that situation would not lend itself to exchange of registrar between full-time academic units and peripheral hospitals.—*Dr. Wright*: There would of course be the odd exception. There are the other sections in the teaching hospital, the man who has set out on a course of research work; and even there one is beginning to pick out the better man.

2654. Your basic idea is that the man should be appointed by the Regional Board and not to any particular hospital and he should work at a variety of hospitals as the service requires?—Yes. Could I make one further point on the question of the initial salary for the consultant. It begins at 32 and goes up. We feel that nowadays the consultant generally is appointed a bit later than that, and we would much favour an initial salary appropriate for age 36, which could be worked down a little if a man were appointed at an earlier age.

2655. You suggest that the normal starting salary should be what is agreed as appropriate for a man of 36. Would that apply once National Service has gone?—If you have the thing so that you can move it down there would be no difficulty anyway.

2656. *Sir David Hughes Parry*: Could it be a matter dependent on the age of entry?—There is a clause which suggests that that could be possible, but my own experience is that it is not used very often. I think with an initial figure a bit higher up, it may be possible to keep a little off for a younger man.

2657. *Chairman*: Would it not be fair with your intermediate grade to have just a straight increase of so much when you move from one to the other?—It would be a little hard on a man who goes up a little later. I think it should vary with age again. I think it should be that if he were 32 it should

be so and so, if he were 36 it should be a bit higher.

2658. On your proposed method, at 32 he would be getting less immediately than he would at 36?—Yes, that is so.—*Professor Alstead*: May I add a word turning to the subject of establishment. I merely want to draw attention to the uneven distribution of consultants in relation to what you might call the clinical load of the units—the clinical units in different hospitals in the country. It does seem to me—and here I speak as an individual—to be anomalous under the National Health Service that there should be these discrepancies between the available consultant manpower for say one group of patients in one hospital and a similar group of patients in another kind of hospital. It may well be that this is a relic of the old days in which there were voluntary hospitals which were rather freely staffed and local authority hospitals which were relatively under-staffed. It may be that the evening process has not quite been brought about, notwithstanding ten years of the National Health Service.

2659. *Pofessor Jewkes*: How do you propose this should be helped?—I refer back to the point made by Mr. Wright, who suggested the time was ripe for a review of the establishments in relation to the responsibilities carried in the different units.

2660. In total or in distribution?—In distribution and total—what is the proper complement in relation to the total responsibilities.

2661. *Chairman*: On the whole, as regards distribution, which hospitals are shortest in establishment?—There may be an E.M.S. hospital in the heart of the country, say in Ayrshire where the relationship between staff and patients is quite different from what obtains in a teaching hospital. It may be argued quite properly that in a teaching hospital there are other responsibilities to be discharged in terms of teaching and research—and there is the full-time clinical unit of the University to minimise that argument. But I still feel there is the over-riding consideration of what we owe to the National Health Service.

2662. *Chairman*: In attempting to establish the proper complement, there is this difficulty about the suspicion of

dilution.—It may turn out to be calculated as some sort of basic requirement for sick people in each area. Perhaps I am over-simplifying the problem. There may be some basic requirement and on that they may claim for additional staff in terms of research—academic research.—*Dr. Wright*: One curious thing is this business of counting the number of consultants—the number of consultants bears no relation to the truth, which must surely be in sessions of consultants. One consultant may have two sessions, and yet he counts as a consultant.

2663. *Chairman*: It appears we have been dealing so much with the hospital side we have not asked you what you think of the system of remuneration by counting heads of patients of general practitioners. Are there any general remarks you would like to make on the method of paying capitation fees?—

Professor Alstead: I personally am not competent to express an opinion on that; perhaps *Dr. Wright* would like to say something about it.—*Dr. Wright*: When the Spens Committee met this same problem and I was asked the same question, I did suggest then that there should be considered some method of remuneration for the man of merit in general practice.

2664. *Sir Hugh Watson*: So did Spens.—That was the evidence given to them. One of the several suggestions made was that there should be a widening of the

Medical Board work, which at that time consisted mostly of refereeing cases of doubtful sickness and disability, and that it could be employed, as was being done in the west of Scotland to supplement the earnings of general practitioners, to which senior members' practice could be added, and they could be paid sufficient salary to allow them to take less patients and not lose. That was objected to because it was salary. I do not know how one can do anything at all without paying a lump sum. I do not accept that the only method of determining whether a general practitioner is a good one or a bad one is by counting the heads on his panel. That would not be accepted by anyone who knows general practice.

2665. Do you think it would help if there were a fixed payment, or what other basis of payment can you suggest?—The use of Medical Board reviewing in a consultative capacity, appointments or sessions, provided there were a reasonable number of sessions, guaranteed sessions—any of these are worth considering. I feel when a man gets to the age of 55 he should be protected a little from the rough and tumble of general practice.

Chairman: If you have any views you would like to put to us on that later, please do not hesitate to do so. Thank you very much for coming and letting us put questions to you.

(The witnesses withdrew.)

ELEVENTH DAY

Friday, 14th March, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MR. A. D. BONHAM-CARTER, T.D.

MR. I. D. MCINTOSH, M.A.

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

SIR DAVID HUGHES PARRY, Q.C.

PROFESSOR JOHN JEWKES, C.B.E.

SIR HUGH WATSON, D.K.S.

MR. S. WATSON, C.B.E.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

Evidence submitted to The Royal Commission on the Remuneration of Doctors and Dentists

1. The Royal College of Surgeons of Edinburgh was founded in 1505. The Seal of Cause, under which it was established, was confirmed by Royal Charter of King James IV in 1506. At this time the Incorporation of Surgeons was charged with certain responsibilities, and accorded certain powers and privileges. Important amongst its rights and obligations was that of practising and teaching the art and the craft of surgery in Edinburgh; and to it fell the duty of ascertaining by examination the proficiency and the attainments of candidates before admitting them to its Fellowship.

2. The College of Surgeons of Edinburgh is the oldest chartered surgical incorporation in Britain; and for the past 452 years it has zealously and constantly guarded its responsibilities, rights and privileges. During those four and a half centuries times have changed and the sphere of influence of the College has progressively expanded, but its original purpose has not altered. The Fellows of the College still practise Surgery, still teach their art and craft, still uphold its standards and the standards of Surgery in general, by examination in respect of the proficiency, and by scrutiny in respect of the personal suitability, of candidates for their Fellowship.

3. The present-day importance of the three Royal Surgical Incorporations of England, of Glasgow and of Edinburgh is evident from the fact that Fellowship of one of them is an essential qualification for a consultant surgical post in the National Health Service; and such is the prestige of these Fellowships that they are regarded overseas as a hallmark of sound surgical education.

4. The Royal College of Surgeons of Edinburgh to-day has a total of 3,371 Fellows throughout the world, of which 1,735 are resident in the British Isles and 1,636 are resident in the Commonwealth and other overseas countries. They include specialists in all the major and minor sub-divisions of Surgery, and its associated disciplines. In addition, there are 143 Fellows in Dental Surgery who represent a "corps elite" of leadership in the profession of Dentistry in Scotland and elsewhere.

5. The Royal College of Surgeons of Edinburgh thus speaks with authority for a large and important section of the surgical profession. In so doing it feels that it should take cognisance also of its potential recruits—the medical students and the junior grades of hospital medical staff.

6. For this purpose the Council of the College appointed a committee of ten Fellows representative of part-time Consultant Surgeons, whole-time Consultant Surgeons both in Regional Hospital Board and in University employment. Senior

Registrars in Surgery, and part-time Consultants in Dental Surgery to assemble and collate the evidence relevant to the remuneration of surgeons, and to associated matters that have appeared important or that have been brought to their notice by the Royal Commission. This it now presents on behalf of the College.

INTRODUCTION

The Place of Medicine in the Community

7. The well-being and the morale of Britain is largely dependent on the maintenance and the integrity of its great professions—the Church, the Law, Medicine and Science. For some four centuries our country has preserved a position of high prestige—often of world leadership—in each of these spheres of human endeavour. Among them Medicine is important in that it is concerned with the maintenance of health, the prevention of disease and the restoration of the sick—with matters, in fact, that have an individual as well as a national significance. The nation looks to the medical profession to discharge these responsibilities to the community as a whole, and to each individual of that community, in his day of affliction, at a traditionally British high level. The College believes that the public will not be satisfied with a medical profession at a lower status than one of world-leadership. It believes, moreover, that if made aware of the relevant facts, the Nation would be willing to make the necessary effort and the necessary sacrifices to secure this objective—an objective that includes such aims as the provision of sufficient and good hospitals, adequate facilities for research, and the proper remuneration of doctors. Conversely, it believes that failure to maintain the prestige of British Medicine would inevitably have a seriously detrimental effect on national morale and on national well-being as well as on individual happiness and efficiency.

The Recent Nationalisation of Medicine

8. With the rest of the community, Medicine has shared in the tendency towards "socialisation" as contrasted with "free enterprise." In the view of the College such levelling trends, with their emphasis on limited responsibility, on routine and on security, while containing many desirable features that may be regarded as improvements in "social justice" are yet not without danger to the efficiency and the status of the learned and liberal professions. Medicine is one of the branches of human endeavour in which a high degree of individual responsibility—and therefore a correspondingly high social status—are necessary if its traditional standards are to be preserved. The College views with some disquiet—and even alarm—the "socialising" effect of a National Health Service that has carried Medicine much further towards "nationalisation" than almost any other learned profession. It views with equal concern the steady and apparently relentless depression of the social and economic status of the doctor that has occurred since 1948. It feels that, in relation to other learned professions, this situation places Medicine in a new and peculiarly unfavourable position in competing for recruits of a high level of culture, intelligence and integrity.

9. The College would remind the Commission that the National Health Service is the first major experiment on the part of the State in "nationalising" a learned and a liberal profession. It should follow that new and more liberal methods of administration are necessary if the experiment is to be a successful one.

Recruitment to the Medical Profession

10. The profession of Medicine is an honourable and a respected one. In the past, its recruits have been men and women of a high standard of culture, of intelligence and of integrity of character; and usually with a strong sense of "vocational calling," spiced with a sense of adventure and the prospect of professional freedom and individual responsibility. Its members have invariably had an opportunity to rise high both socially and economically, though often at the expense of personal leisure and social pursuit. These attractions and opportunities have inspired the established doctor throughout his professional life and stimulated him to his best endeavour. It would be idle to ignore the fact that doctors are human,

and subject to the weaknesses of human nature, however; for most of them a vocational urge must be supplemented by other inducements. The College notes with disquiet the curtailment or the loss of former incentives that have followed the introduction of the National Health Service. Prominent among these is the reduced remuneration of the doctor now and, unless there is some change of outlook, in the future.

The Profession and the Spens' Report

11. The College recalls that in 1948, along with the rest of the Medical Profession, its Fellows agreed to accept contracts in the National Health Service. They did so reluctantly, and only because the Government accepted without qualification the terms of the relevant Spens' Report on the Consultant and Specialist Services.

12. The failure of the succeeding Government to uphold the undertakings of its predecessor and to honour its moral obligation to the profession has caused progressive discontent and continued financial hardship among many of the Fellows of the College. The College is of the opinion that recruitment to Medicine, and particularly to its Surgical Division, will necessarily be seriously affected by this regrettable state of affairs.

13. The College does not insist that the Spens' Report on Consultant and Specialist Services should for all time be considered sacrosanct in every detail; but it does consider that the lower standard of living now accorded the profession by a Government that has failed to honour the straightforward undertakings of its predecessor constitutes a breach of faith, and an unfortunate start to a promising, if difficult, experiment.

14. The College believes it to be vitally important that in the field of Surgery the long and exacting training, the long and often arduous hours of work and the high responsibilities should be compensated and rewarded by a remuneration sufficient to maintain the reasonable standard of living that should be enjoyed, and was formerly enjoyed, by a learned and liberal and exacting profession.

15. The College is grateful for the opportunity of making its views known to the Royal Commission. It realises that the task of the Commission is a difficult one; and in the pages following it has sought to answer helpfully those questions asked by the Commission on which it considers it can speak with authority.

ANSWERS TO THE QUESTIONS ASKED BY THE ROYAL COMMISSION

Question 1

"What is the quality and quantity of recruits (a) offering themselves, (b) accepted for training as medical students?"

16. The over-all number applying for medical training is slightly falling, and the number suitable for recruitment to the medical profession is even more seriously affected. The College notes that of those accepted there is a considerable proportion of unsatisfactory entrants, and it seems probable that there has been a deterioration in the average quality of medical student during the past ten years.

17. One reason—an important one—for the decline in quality and in quantity is the recognition that Medicine as a profession has become less attractive since the introduction of the National Health Service. The curtailment of freedom, the disappearance of such incentives as adequate remuneration and the increased duration of successive training periods—before graduation, before registration and before consultant status is attained—are important factors in diminished recruitment. Although the increased duration of training is not an effect of the National Health Service, it is a circumstance that merited some recognition—and compensation—by any who desired to preserve the attractiveness of Medicine as a worth-while career.

18. Medicine, in fact, has been placed at a particular disadvantage in competing for the highest quality of recruits with other vocations and other learned professions and callings.

Question 2

"The quantity and quality of newly qualified doctors."

19. The quantity of newly qualified doctors at present required and at present available, and the quantity likely to be required in the proximate future have recently been investigated and determined by the Willink Committee (1957), and other comment would be pointless. It is not the view of the College that there has been any striking change in the professional ability or competence of the newly qualified doctor. Nevertheless, there has been a distinct alteration in the attitude of some of the new recruits. In particular there appears to be a general tendency—almost an undue pre-occupation—to insist on such "rights" as off-duty time, leave, and similar matters. The vocational urge, the willingness to sacrifice in the pursuit of professional ideals, is less evident than formerly. The College believes that one reason for this adverse change is the impact on those young doctors of an ill-adapted administrative machinery.

Question 3

"The wastage of men and women during training and in the first few years after qualification."

20. The 6-year curriculum of the Scottish Medical Schools includes a first year which is largely pre-medical and leads to a First Professional Examination at the end of it. In many English Medical Schools the content of this first year is covered at the secondary school, and a 5-year curriculum starts at the First Professional Examination level. Thereafter, all British Schools have 2 years of pre-clinical studies, and 3 clinical years before graduation, followed by a year of hospital apprenticeship experience prior to admission to the Medical Register.

21. The College is indebted to the Faculty of Medicine of the University of Edinburgh for the information that of the students starting Medicine in the years 1948, 1949 and 1950, the average wastage was 21.5 per cent. The majority of these failures occurred in the first three years; thereafter the wastage was relatively small, and comparable to the figure of 6 per cent for the comparable training period given in the Willink Report. The cause of the high wastage in the early years is in the main the unsatisfactory average ability of the entrants, and some reasons for this are considered in the answer to Question 1.

22. The distribution of the wastage suggests that the First and Second Professional Examinations are reasonably efficient filters for entrants to Medicine. In Edinburgh, of those accepted for medical training, approximately 80 per cent are men and 20 per cent are women. The wastage figures for men and women are nearly equal. Amongst the men, wastage is mainly caused by the admission of "unsatisfactory students." The proportion of women accepted in relation to those applying is lower than in the case of men, so that women medical students are a more highly selected group, and the proportion of "unsatisfactory students" is substantially less; the wastage figure approximates to that in the male group for reasons peculiar to women.

23. A recent survey indicates that the wastage of either men or women doctors in the first few years after graduation is not such as to cause serious concern.

Question 4

"The cost and duration of training and the extent to which the cost is, or should be, met from grants (including both the adequacy of the grants and the proportion of students receiving them)."

24. The cost of training appears to be reasonable; it is largely (approximately 80 per cent) borne by the Exchequer, the fees chargeable to the individual student amounting to slightly less than 20 per cent of the total. A more formidable item to the student is the cost of subsistence during training. In Edinburgh about 60 per cent of medical students receive grants in aid of their training and this proportion is close to the average for Scotland. The College considers that the "means test" of the parents, which governs eligibility for these grants, should be related to *nett parental income* after tax deduction rather than to the gross

income. This would help to ease the burden on professional men whose children wish to study Medicine without inhibiting recruitment from other sections of the community. Grants to students in England and in Scotland should be comparable.

25. As noted under Question 3 the "pre-medical" training—which occupies the first of the six academic years in the Scottish Universities—is often provided at secondary school level in England and is excluded from the medical curriculum in many English medical schools. A Local Authority in England may be unwilling to provide a grant in aid for one of their pupils to study in Scotland because this would commit them to an additional year's expenditure. This potential barrier to a free choice of Medical Training School should be eliminated.

26. The College is of opinion that the present total duration of medical training (to medical registration level) is undesirably long and should be curtailed.

Question 5

"The position and prospects of a newly qualified doctor."

27. The College notes that "qualification" is now a somewhat extended process. At the end of his six-year academic curriculum (five-year in many English Universities) the medical student receives his academic sanction. He then proceeds to an apprenticeship in approved hospital posts for a further seventh year before he is accorded medical registration, which entitles him to practise medicine in Britain and countries that reciprocate with Britain in this matter.

28. *The Pre-Registration House Officer.* The new graduate experiences the satisfaction of achievement, and his prospects of securing an "apprenticeship" post as a pre-registration House Officer are good, since at present the number of vacancies exceeds the number of doctors in the first year after graduation. There is, of course, keen competition for the more desirable posts, and this is as it should be.

29. Some doctors at this stage have already decided what branch of Medicine they desire to follow, and make appropriate plans. Others must savour other branches of medical practice at House Officer level before coming to a decision. For others again opportunity may be the main factor that determines the choice of an ultimate career.

30. The College recognises that the immediate prospects at this stage are infinitely better to-day than they were a generation ago, but it considers that the terms of employment still leave much to be desired. As one who has spent five or six years in training, the House Officer is insufficiently remunerated, even as an "apprentice." He is required to sustain considerable responsibilities for the sick, and he is required not only to put in a long and arduous day's work, but to provide also an efficient night service. To ensure his constant availability for this latter duty he is required to live in hospital. To these heavy and exacting commitments are added such administrative irritations as the practice of charging him for board and lodging, even when he is on statutory leave, and his locum is also being charged. Although this apparent iniquity is said to be due to the method of accounting, it cannot appear as other than an injustice to the young doctor. Again, discontent has been generated by the exceedingly variable—and sometimes very poor—quality of the board and lodging provided in different or the same hospitals for the same financial charge. The College strongly urges a properly adjusted remuneration, and the abolition of board and lodging charges.

31. The "proper adjustment" envisaged is an approximation to the Spens recommendation (brought up to date), minus something considerably less than the value of the average board and lodging provided.

32. *The Registered House Officer.* The newly registered practitioner finds himself confronted almost at once with the necessity of electing to follow one of the many branches of his profession and of adhering to it thereafter. Such early restriction of choice is unfortunate, as many young registered practitioners are not yet sufficiently mature or experienced to make a decision at that stage.

33. This situation has arisen in part because of the financial rigidity of the National Health Service. For example, if a newly registered doctor enters general practice as a trainee assistant, and, within the next year or two elects to enter the hospital service, he can do so only at considerable immediate financial sacrifice. Conversely, should a newly registered doctor after a few years in the hospital service, perhaps up to registrar level, decide that he is better adapted for general practice or some other branch, the change again entails considerable immediate financial sacrifice.

34. The College, of course, is well aware that the barriers to interchange of personnel at those levels are not solely due to financial considerations. In part the difficulty is the result of a failure of co-operation between the several branches of the profession itself, and the remedy for this is in the hands of the profession.

35. The College suggests that:—

(a) Registered House Officers should be given a salary increment at each subsequent six-months period up to two years. The salary applicable to the first six months should be equivalent to that payable at a similar stage in general practice and in the other branches of Medicine open to the newly registered doctor. The young doctor would thus be encouraged to complete at least four, and up to six, half-year terms as House Officer (two pre-registration and up to four post-registration); (b) a system might be evolved (with suitable safeguards) whereby a minimal salary value could be attached to an individual according to his years of service in the training period, irrespective of the statutory salary of a particular post.

36. This system already exists in the hospital service in respect of the salary increments attached to each of the first three House Officer periods of six months—that is up to six months after registration. Thus the House Officer to Ward A receives "X" salary if it is his first half-year period; but on another occasion the House Officer to Ward A may be in his third half-year period and he then receives "X + 2" increments salary in the same hospital post.

37. The College feels that this system could, with advantage, be extended to cover at least the first four or five years following registration, and to apply to a doctor who leaves the hospital service to enter some other branch of Medicine.

38. The College believes that (a) would help to secure a higher general medical standard by encouraging young doctors to undertake up to six House Officer posts before embarking on a chosen branch of Medicine. Incidentally, it would assist in resolving the increasingly difficult problem of hospital staffing at House Officer level.

39. It suggests that (b) could assist materially in freeing the channels of interchange between the branches of Medicine in the early years after registration, and thus contribute to a more efficient and a more contented medical service.

40. *The Senior House Officer.* The Senior House Officer category was introduced largely to accommodate young doctors who returned to the hospital service after their period of National Service. Nevertheless, a young doctor, in fact, becomes eligible for such a post after completing his two pre-registration House Officer posts. The position, therefore, possibly corresponds to the later House Officer posts suggested above, and to the evanescent "Junior Registrar" of the Spens' Hospital Service Report. The Senior House Officer post is often non-resident in a Hospital Surgical Division.

41. To the College there seems no particular virtue in a distinct name or category for this stage of training provided that the House Officer sequence is extended up to three years with salary increments as suggested above, that National Service is credited for increment purposes, and that a non-resident category of House Officer is recognised and remunerated accordingly.

42. Not infrequently a Senior House Officer, who is habitually non-resident, is required to live in hospital for short recurrent periods in order to relieve a junior resident colleague. On such occasions the relieving doctor should not be charged for board and lodging, as he is assuming additional night work and has to retain—and pay for—his outside lodging arrangements.

Question 6

"Any trend to excessive resort to certain branches of the profession at the cost of others."

43. The College observes that in the period 1946-52, and in diminishing degree since, there was a trend on the part of recently qualified doctors to seek Registrar posts in the major specialities. Though the effect of this has been serious as far as the Registrars themselves are concerned, the numbers have not been sufficient to deplete other branches of the profession to any considerable extent. (See Question 8 concerning Registrars.)

44. In certain of the "minor specialities" of surgery, such as Otolaryngology, Ophthalmology, Anaesthesia (and, it is understood, in Radiodiagnosis, Radiotherapy and in Psychiatry), there is now a deficit of doctors undergoing specialist training. The College considers that the laws of supply and demand may be expected to correct such deficits and ensure a sufficiently even distribution within the profession.

45. On the other hand, the College notes a diminished recruitment to the hospital service at House Officer and Senior House Officer level, i.e. in the first and second year after registration (second and third year after graduation). Young doctors tend to enter general practice or other branches as soon as possible after registration, attracted by the prospect of immediate financial improvement and by a natural desire to "get on in life quickly" rather than to "waste time" in a further period of hospital training. Such a trend is obviously inimical to the maintenance or the betterment of medical standards; and it jeopardises the structure of hospital staffing at this junior level. As already stated in the reply to Question 5, adjustment of remuneration is one means of correcting this tendency and of making the second and third year of House Officer posts more attractive, and more comparable in their immediate rewards, to the other openings available to the young doctor.

Question 7

"The relative advantages and disadvantages, financial and otherwise, of service as:—

(c) a whole-time consultant in the National Health Service."

46. The College appreciates that some surgeons feel that they can do better work as whole-time consultants. They are then assured of a fixed income (and a reasonable one if the Spens' recommendations were implemented); and this is secure. Furthermore, without the anxiety and the distractions of private practice, they may have increased opportunities for clinical or for laboratory research.

47. The disadvantages are that they may be unable to treat that section of the public that prefers private accommodation and personal financial relationship with its surgeon. This is especially cogent in areas where there is insufficient or no hospital accommodation for patients who wish privacy and are able and anxious to pay for it. The whole-time surgeon is thus restricted in his contacts with a section of the public that is socially and often intellectually important.

48. The whole-time consultant is also at a disadvantage in respect of allowances for professional expenses in respect of income tax assessments. (See Question 12.) He is also required to make the first eight domiciliary visits of each quarter-year without remuneration. This is an irritating and unjust residue from an earlier and more restrictive regulation whereby the whole-time consultant was not remunerated at all for any domiciliary visits. The College urges that a practice so manifestly illogical be abolished.

"(d) A part-time consultant with the maximal number of sessions."

49. The College is aware that most of its Fellows resident in Britain prefer this arrangement. The competitive element in their private practice is a healthy spur to their best endeavours. They feel that a cultural advantage accrues from contact with those who elect to seek private surgical care and accommodation. They derive a sense of freedom from the fact that two-elevenths of their time is absolutely under their personal control and for this period at least they are entirely

their own masters. They have the advantage of nine-elevenths of an income that would be reasonable if the Spens' recommendations were implemented, and which is secure. To this they can add the more speculative rewards of their private practice.

50. Although private practice has greatly diminished since 1948, it is probable that the maximal part-time surgical consultant, on the average, earns more than his whole-time colleague; and that some few earn considerably more. The part-time consultant has also some advantage in respect of allowances for professional expenses, and the recognition of such expenses for income-tax purposes. (See reply to Question 12.)

51. The disadvantages of the part-time surgical consultant arrangement are the result mainly of the lack of adequate facilities for paying patients in hospitals. In many areas "pay-beds" are not provided or are too few; or too expensive to be within the reach of any save the very wealthy. Surgical technique is becoming progressively more exacting, and the best facilities cannot be provided in small nursing homes. These cogent factors force the surgeon to take his wealthier patients as non-paying patients to hospitals where technical facilities exist. The College considers this situation doubly unfortunate. Not only does it deprive the part-time surgeon of several of the advantages mentioned above; it deprives the National Health Service of a source of income that appears a perfectly legitimate and desirable one in Britain to-day.

52. The College would therefore urge the provision throughout the country of adequate pay-beds suitably graded in surgical hospitals and of facilities for private practice there.

53. The College, of course, recognises that the notable decline in private practice since 1948 has to some extent been compensated for financially by the whole-time and part-time salaries now paid to members of hospitals staffs who were formerly "honorary" and unremunerated. It is unable to foretell whether in future the decline in private practice will continue or whether it will be arrested by the increasing development of provident insurance schemes.

54. The College notes a theoretical disadvantage of the part-time surgical contract in that a surgeon who found himself overwhelmed with private practice might tend to neglect his duties to his non-fee-paying patients. Such an instance has not come to the notice of the College. Indeed, its experience in this matter is that the part-time surgeon who excels in private practice is an equally excellent and dutiful surgeon in respect of his hospital practice.

"(c) a part-time consultant with only a few sessions."

55. The College considers that this arrangement should be exceptional and never imposed.

56. As regards (c), (d) and (e) the College approves the present practice of offering certain surgical consultant contracts as either whole time or maximum part time, the choice being left to the successful applicant. A revision of this choice should subsequently be open to the consultant at suitable intervals—perhaps 3-yearly.

57. The College considers that a surgical consultant post (or group of associated posts) should not be offered at less than nine-elevenths part time. Any smaller number of sessions should be agreed only at the specific request of the individual surgical consultant concerned.

58. The College notes, incidentally, that at present there is considerable discrepancy, from region to region, in the number of sessions allowed for comparable and equally onerous posts. This anomaly would be eliminated if nine-elevenths part-time contracts were the general rule. The College considers that the average proportion of private surgical practice to non-fee-paying surgical practice is considerably less than a two to nine ratio.

"(g) a doctor in any other sort of practice or employment":—

59. A whole-time University clinical teacher is generally in honorary contract with the National Health Service. At consultant level the University post is usually that of Senior Lecturer, Reader or Professor. These honorary consultants in the National Health Service may enjoy special facilities for teaching and research.

Expenses for professional travel are more readily obtainable than in the National Health Service; their income is secure and it may be assisted by family allowances and by educational reliefs in respect of children.

60. The College notes that in recent years their salaries have been equalised with those of whole-time consultants in the National Health Service, and they are eligible for merit awards, though the financial "ceiling" attainable is usually somewhat lower in the case of the University post. The College is concerned that this equalisation should be strictly maintained in future.

61. The whole-time University teachers are ineligible for remuneration for domiciliary visits. They are under the same disadvantages as the whole-time N.H.S. consultants as regards expenses and the recognition of professional expenses for income tax purposes.

"(f) a Senior Hospital Medical Officer."

62. The College is of the opinion that this grade is inapplicable to surgery. It is statutorily inapplicable in England and Wales, except in the case of certain "Casualty Officer" posts, an exception which the College views with disapproval. In Scotland, the exclusion of this grade in surgical staffing has been largely honoured.

63. The sequence of rungs in the surgical ladder is—Registrar, Senior Registrar, and Consultant. The absence of the Senior Hospital Medical Officer grade in surgery should be clearly borne in mind in contemplating this surgical sequence from the point of view of remuneration.

64. The College notes that the S.H.M.O. grade was introduced to accommodate and to provide careers for certain limited specialists, working in limited fields—associated with limited responsibility. The College believes that this grade should continue to be excluded from the surgical sequence.

Question 8

"The difficulties encountered by members of the Registrar Grades."

65. The College considers that Registrar Grades are insufficiently remunerated and that they encounter formidable difficulties regarding promotion within the hospital service or, alternatively, in finding a suitable outlet from it. As with the House Officers, responsibility for insufficient remuneration appears to lie at the door of the National Health Service; so also may be the degree of financial rigidity that renders difficult a move from one branch to another. However, the College considers that the profession itself is equally responsible for some part of the present difficulties of promotion and of movement from one branch to another.

The Surgical Staffing Pattern

66. A generation ago Britain was exporting large numbers of trained surgeons to the Commonwealth countries and elsewhere overseas. With the development of medical training facilities in those countries the export of trained surgeons is very greatly reduced to-day. A generation ago the Hospital Surgical Staffing pattern reflected this "export" function. The proportion of "trainee staff" to consultant staff was much higher than a self-contained surgical community could absorb; the trainee staff was partly "for export." There is no doubt that British surgeons had become accustomed to, and attached to, this staffing pattern and they find it no easy matter to alter it to-day. It is, of course, also a relatively inexpensive system and as such it has an obvious attraction to administrators of hospital finance.

67. The College has no doubt that the pattern must be altered so as to co-ordinate the proportion of surgical specialist trainees with the anticipated consultant vacancies and with the small amount of "export" that still continues. To achieve this, and to man the service, the proportion of consultant surgical posts must be increased. As the hospital service is also expanding the numbers of new consultant posts required is very considerable. The future distribution of a diminished number of surgical specialist trainees is, perhaps, an "intra-professional" problem; but the

College believes that they should be located only where they can obtain the best training. Surgical training posts should not be allowed in most non-teaching and peripheral hospitals; the surgical staffing of such hospitals should be provided by an increased consultant force, by House Officers, and with increased technical assistance. This is a more expensive staffing pattern; but with diminishing outlet for trainees it is necessary. In addition to adjusting present individual salaries in conformity with the Spens' Report, this measure demands an increase of proportionate and of actual consultant establishment; and the College hopes that despite the financial implications the Royal Commission will see its way to recommend it.

68. The registrar situation has been aggravated by an excessive entry of Registrars into the Hospital Service in the period 1946-52. At this time, soon after the War, many young doctors were returning from War Service, the mood of the time was expansionist, and the prospects of the Hospital Service as outlined in the relevant Spens' Report seemed attractive. This temporary factor, together with the more gradual and extended diminution of surgical "export," accounts for the present excess of Registrars. Some few of them apprehended the impossibility of the situation sufficiently early to transfer to another branch of Medicine (often at immediate pecuniary sacrifice) or to emigrate. But to-day a large number of them remain, unable to achieve promotion and unable to move elsewhere. The College feels it only fair to these young men to point out that they received every encouragement to enter, and to remain in, the surgical Hospital Service from seniors who have adhered to the pre-war staffing pattern for too long, and from the National Health Service Administration, who, no doubt unaware of the implications, used them as the cheapest man power available for the tasks in hand. The College suggests that the relief of this predicament should come under the most careful scrutiny by the Commission.

Staffing and Training Posts.

69. In connection with the surgical Hospital Staffing pattern it should be noted that the junior medical staff are performing two distinct but closely related functions. They are gaining knowledge and experience—undergoing training; and they are caring for the sick—working as doctors under supervision. The two functions are indissolubly linked, since doctors can learn only by experience and by assuming increasing responsibility.

70. Nevertheless, an attempt has been made to distinguish "staffing posts" from "training posts" in the junior (non-permanent) hospital staffing. The College considers this distinction to be fallacious. A qualified doctor should not occupy any junior hospital post except he is there to learn by it and to fit himself for higher responsibilities, as well as to help in the care of the sick. In the more junior—the House Officer—grades of the junior hospital staff his training may be regarded as of general medical value, no matter what branch of Medicine he finally adopts. In the more senior grades—Registrar and Senior Registrar—his training is orientated towards specialist surgery.

71. At this point it may be convenient to consider the Surgical Registrar and the Senior Surgical Registrar separately:—

72. The Surgical Registrars were envisaged as the first specialist training cadre for surgery. A doctor might expect to gain such an appointment at two to four years after graduation, in the absence of National Service, or three to five years after graduation, if called upon for National Service soon after registration. The period of such a registrar appointment was intended to be two years with a possible extension to three years. Doctors accepting such posts feel they have a personal bent towards specialisation in surgery.

73. *Selection.* The posts are widely advertised and appointment to them is selective, under the scrutiny of advisory appointments committees. The successful applicants are potential surgical specialists "on approval."

74. *Outlet from the Grade.* The most highly approved find their desired outlet from the category in promotion to the more limited cadre of Senior Surgical Registrars—again passing the bar of open advertisement and advisory appointments committees. An outlet for the unpromoted remainder has proved very difficult

to find. At present it may be at least six to eight years after their graduation in Medicine before doubt arises as to their further prospects—doubt variously attributed to temporary lack of opportunity for promotion or to personal unsuitability. The natural tendency is to try a little longer; and in this the Registrar has been encouraged, because his relatively inexpensive working services are in demand. The years slip by, he continues to fail of promotion. Perhaps he is now of eight or ten years' standing in Medicine and the outlet to another branch of Medicine, more suited to his capacities, is even more difficult to realise than it was two years before. His most serious obstacle now is that he will usually have to start again on the lowest financial rung of the ladder in any other branch; and meantime he may have acquired family responsibilities.

75. The College suggests, as mentioned in the reply to Question 5, that transfers at this level would be facilitated by attaching a salary-value with suitable "ceiling" safeguards to individuals according to their years of service so that they could move to a lower "post-level" in another branch without immediate financial loss. In other words, movement out of surgical specialist training would be subsidised. The College considers that, in spite of all the selection safeguards that can be devised, it is unavoidable, in the interests of a high surgical standard, that the numbers of Registrars should be larger than the "promotion outlet" can deal with. The Registrar period is, in fact, a further selection period, and financial methods to subsidise the movement of those who fail into other branches of Medicine are required.

76. It should be noted that the Surgical Registrar category is augmented by inclusion with it, for practical purposes, of whole-time University Clinical Lecturers holding honorary Registrar appointments in the National Health Service; and also by certain Junior Hospital Medical Officer posts, which are approximately equivalent in salary, are subject neither to advertisement nor to scrutiny by an advisory appointments committee, and are made by the Hospital Boards of Management in response to nomination by the senior staff.

77. The Senior Surgical Registrars constitute a still more highly selected and a more advanced group of surgical trainees. It is the group from which consultant surgeons are finally selected.

78. *Selection.* Since Senior Registrarship is still a period for selection, in spite of all precautions a few "rejects" are inevitable. Admission to the grade Senior Registrar is again by open advertisement and the scrutiny of advisory appointments committees. In practice, the Senior Registrar is usually of some six to nine years' medical standing when appointed. It was envisaged that they would serve for three or four years in this category before becoming eligible for consultant status. In fact, those of them who have achieved promotion have usually served for more than four years, and indeed some who have not yet secured consultant posts have been as long as seven or eight years in the Senior Registrar Grade.

79. *Outlet from the grade of Senior Registrar.* Most of these men, having been very stringently selected, are suitable for promotion, and, in contrast to the Registrars, almost all Senior Registrars should find their outlet from the grade by promotion to consultant status, rather than by movement into other branches of Medicine. The College notes with concern that there is to-day a serious accumulation of well-trained, valuable and desirable Senior Registrars who at present have insufficient prospect of promotion. It suggests that this situation could be solved, in its financial aspects, in two ways:

- (a) by increasing the total salary allocation to the surgical branch of the Hospital Service, and thus making possible the desirable increase in consultant establishment; and
- (b) by filling in the gap that exists in salary scales between the fourth year Senior Registrar and the starting salary of the consultant by at least four further yearly increments in the Senior Registrar scale to a level just below that of the beginning of the consultant scale. This measure would render more elastic the reasonable duration of a Senior Registrar post—as experience now suggests is desirable.

80. The College believes that were these measures fully implemented the present "Senior Registrar Problem" would be largely solved. It recognises the future duty of the profession, in concert with the administration, to maintain a reasonable numerical proportion between Senior Registrar posts and anticipated consultant vacancies by careful individual selection against the background of a calculated number of posts. Even at the Senior Registrar level, however, the most careful selection methods sometimes fail. Furthermore, even when the original selection has been correct, the subject of it may, in fact, change his nature. In such rare instances an arrangement for subsidising transfer to another branch of Medicine should be applicable. Without doubt the individual will be a good medical man, in view of his selection as Senior Registrar in Surgery; and although he ultimately proves to be unsuited to the practice of Surgery, he may well prove a recruit of first-rate quality in another branch of Medicine.

81. The Surgical Senior Registrar category is also augmented by inclusion with it of University Clinical Lecturers who hold honorary Senior Registrar contracts in the National Health Service. It is important that this group should not be lost sight of in computing the desirable ratio of Senior Registrars to Consultants.

Temporary Registrar Appointments for Overseas Graduates

82. There is another small group in the Surgical Registrar and Senior Registrar category of which cognisance should be taken. It consists of surgical trainees from overseas who desire to gain training in, and experience of, British Surgery. Training in Surgery can only be accomplished by experience with responsibility; and these men are rightly accepted, after careful selective scrutiny, as trainee members of British Hospital staffs. Like our own men they give service and they gain experience. They are, of course, intended largely for "re-export," but there are enough of them to be taken into account when computing the desirable number of Registrars and Senior Registrars.

Problems Common to Both Grades of Registrar

83. Returning to the problems common to both grades of Registrar, the College notes that such appointments are exclusively whole-time. In consequence, they suffer similar disadvantages in respect of professional expenses allowances as was noted in respect of whole-time Consultants.

84. The College is not satisfied that Registrars and Senior Registrars need be exclusively whole-time appointments. It suggests that they might optionally be maximum part-time, and exceptionally even less than maximum part-time. This might recapture some element of the spirit of adventure and of individual enterprise of an earlier period. The more enterprising could find opportunity for augmenting their incomes and widening their experience by such additional activities as research, teaching on a basis of private enterprise, assisting in general practice and the like.

Question 9

"The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants."

85. The only aspect of this problem of which the College has special knowledge, viz., the difficulties that confront the surgical trainees who desire to transfer to general practice—has been dealt with under Question 5, and particularly Question 8.

Question 10

"The importance of private consulting practice as an incentive to entering the consultant branch of Medicine."

86. The College considers that the prospect of private practice is frequently one factor, and may occasionally be an important factor in influencing a young doctor to adopt a career in surgery. It is certainly a much less important incentive than it was before the War when a consultant's whole income depended on private practice, however; it probably plays only a small part to-day in the choice of a career in the consultant branches of Medicine.

Question 12

"Comparative treatment for income tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service."

87. The College considers that the attitude of the authorities towards expenses necessarily incurred in the adequate performance of consultant work is one of the most irksome and unfair frustrations that have followed in the wake of the Health Service. In this respect the treatment of doctors in this country is markedly different from that obtaining, for example in Canada and the U.S.A. Furthermore, it is contrary, not only to the spirit of the Spens' Report, but also to its letter. It is hardly necessary to point out to the Commission that a surgeon requires the regular use of a motor car, and of a telephone which must at all times be carefully attended, since he is always liable for important emergency calls connected with his hospital duties. Furthermore, since surgery is by no means a static branch of human knowledge the surgeon must constantly be advancing his knowledge by membership of learned societies, travel to and attendance at professional meetings and the purchase of new professional books and surgical periodicals. The College considers that it is quite unfair that the whole-time consultant should receive no income tax allowance for such obviously legitimate expenses. He can reclaim his outlays in respect of telephone calls on hospital business, but this in no wise compensates him for the heavy rental of the telephone of to-day nor for the expense incurred in ensuring that it is constantly manned. He can also claim mileage for the use of his car under certain specific circumstances, but the meagre mileage allowance does not compensate him for the purchase, maintenance, depreciation or renewal of his vehicle. Furthermore, even the whole-time consultant must necessarily use part of his residence for study if he is to keep himself abreast of modern developments in his specialty. It is just as important for him to have access at his home to the latest sources of information as it is for the advocate to have a study lined by shelves of Law Reports.

88. If the treatment of the whole-time consultant is deplorable, his part-time colleague at the moment is little better off. As the Royal Commission will know, part-time total incomes—salaries and private practice earnings together—were formerly taxed under Schedule D. Recently the Inland Revenue authorities have taxed the salary part of the income of part-time consultants under Schedule E and only private practice earnings under Schedule D. This recent change has been resisted by part-time consultants and although the special Commissioners found in their favour, the Inland Revenue authorities have appealed against this decision; the hearing of the appeal is pending. In the meantime, the young part-time consultant who has little or no private practice is allowed only a meagre deduction for legitimate expenses and his plight is indeed a sorry one.

89. The College respectfully suggests that the Commission should urge that medical men should receive special treatment in the matter of professional expenses. It believes also that the need to entertain professional colleagues, especially those from overseas, should be regarded as a necessary expense for income tax purposes. It is hardly necessary to point out that the exchange of views with distinguished visitors who are often the authors of new techniques or world-wide authorities in their subjects can only be of the utmost value to the efficiency of the National Health Service and to the prestige of British Medicine. British doctors who travel abroad are invariably treated with the greatest of kindness and generosity and are able to accept hospitality because they know that in other countries their hosts are in large part compensated for it.

Question 13

"Any anomalies in the method of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume."

The Remuneration of Surgeons in General

90. The College suggests that in determining the remuneration of Consultants in Surgery, due regard should be paid to the exacting nature of their work. The practice of the various surgical specialties is arduous; indeed no other branch

of Medicine compares with it in respect of physical effort. The duties of the surgeon require a high degree of knowledge, judgment and skill; and they impose an extraordinary stress of responsibility and of physical endurance. The training period of the surgeon is long and his working life relatively short. The length and complexity of modern operations, the strain of emergency surgery with all its implications, and the grave responsibility assumed by the surgeon on behalf of his patient—these and similar considerations mean that most surgeons to-day are subject to great mental and physical strain, and are over-worked. As a compensation for this the College suggests that a larger financial allocation should be made available to the surgical division of the Health Service, for the increase of surgical consultant establishment.

Consultants on Less Than Maximum Part-time

91. The College considers that the remuneration of consultants at less than a maximum part-time salary often constitutes an anomaly. This is especially cogent in the case of consultants of the younger age groups, since private practice has diminished, and little of what remains may come their way. Their total income may then be seriously insufficient. As noted under Question 7 (d), the College considers that all surgical part-time consultant posts should be offered at not less than maximum part-time.

Senior Registrars

92. Another anomaly of payment is that of the Senior Registrars after their fourth year increment of salary. This is commented on, and a suitable adjustment is proposed, in the reply to Question 8.

Question 15

"General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system."

93. The College views with favour the system of merit awards. It considers that the remuneration of consultants should be adapted to correspond with a high-level plateau from which should rise some "glittering peaks," admired and desired. It feels that in its influence on recruitment to medicine as a profession, and as an incentive to high endeavour, the rewards for great achievement in the field of Surgery would be comparable to those available in other higher vocations and learned professions. It feels that the general social levelling trends have gone far enough in Britain today; and that they should not be emphasised in the field of Surgery by failure to provide sufficient reward for exceptional merit. With this, and particularly with recruitment, in view the College considers it of fundamental importance that the merit award payments, which are at present ungenerously assessed at the Spens 1939 values, should be brought into line with the present day value of money.

94. The College believes that the method of allotting merit awards that has been evolved is probably the best method that can be achieved. It has no suggestions to offer for an alternative system or method of administering it.

Question 16

"Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners."

Surgical Consultants

95. The College invite the attention of the Commission to the fact that in the press and in debate the salaries of surgical consultants are commonly described and quoted in terms of whole-time salaries, and often maximal whole-time salaries.

96. In fact, most surgeons are employed on part-time contracts; and of these a large number in Scotland are employed on a sessional basis varying from six to eight-elevenths. This often inadequate part-time salary is further impoverished by failure to maintain the Spens standards in terms of present-day money value. The College believes that a large proportion of surgical consultants are suffering

a considerable and inappropriate degree of financial stringency; and it has already proposed that, except in very occasional circumstances, no surgical consultant should be paid at less than the maximum part-time salary.

Senior Registrars

97. The Senior Registrars are particularly unfortunate. In their instance especially, the Spens Committee's time-estimate has proved fallacious, in that it envisaged them as men between about 28 and 32 years of age. Actually they rarely enter the grade before the age of 31, and with the dim prospects of promotion at present, they may have to remain in it almost indefinitely. There is no provision for salary increments beyond the fourth year of tenure. At this stage their lot is indeed hard. Underpaid to begin with through failure to bring salaries up to present-day money values, with the financial disadvantages of whole-time employment, and having reached their meagre financial ceiling in four years, they continue their arduous and increasingly valuable service to the sick in hospitals. With increasing family commitments and an increasing need to "make a good appearance" in conformity with their increasing seniority and responsibility, with promotion prospects seeming forever to recede before them, they are expected to "carry on"—and on!

98. These are our brilliant young surgeons—the surgical consultants of the future. In the vast majority of cases their lack of promotion is not through lack of merit, but through lack of opportunity. Frequently they are doing the work of consultants, of whom there are not enough. Their plight is traceable to the deficit in the consultant establishment of the National Health Service, which in effect means inadequate financial provision for the surgical side of the Service; as also to the premature freezing of their financial ceiling after four years in their grade. The College regards as essential to the survival of British Surgery as we have known it the remedial measures mentioned in its reply to Question 8.

Superannuation

99. The College observes that the National Health Service Superannuation Scheme was inaugurated somewhat abruptly in 1948 along with the Service. Immediately preceding this was the War period 1939-46. Those who were "consultants" in Britain's Hospital Service before 1939 were almost entirely dependent on private practice for their incomes up to that date. In those days a surgeon rarely obtained a substantial income from private practice earlier than some ten years after achieving consultant status. Thus, a doctor who became a consultant hospital surgeon in 1929 had been able by 1939 to set aside but little financial provision for his ultimate retirement. During the War most of these men were on active service with no opportunity of private practice. Those whose duties lay at home manned the Emergency Medical Service and neither surgeons nor their wealthier patients had much opportunity for the amenities or the profits of private practice in the War years. After the War this situation had not recovered when the National Health Service intervened and seriously diminished the opportunity for private practice.

100. Surgeons who became hospital consultants about 1930 had at the time of their appointment reasonable prospects of achieving an income between 1940 and 1960 such as would have enabled them to provide suitably for their retirement. They have been unable to realise this—partly by reasons of the War, and partly of the National Health Service. Unable to provide earlier, they are now eligible only for that fraction of pension accruing for the years between 1948 and their retirement. Yet these are the surgeons who brought to the National Health Service the unvalued and the invaluable asset of the living traditions of British Surgery, who in effect have been the means of giving the Service the good start it has had. The College feels that some special compensatory superannuation arrangements should be made for consultants in this category.

Question 17

"Special considerations of which account ought to be taken in discussions of medical remuneration."

101. The medical profession in Britain has hitherto enjoyed a high standing in the community as a profession of learning, and one with great traditions of service. Its prestige has been at the level of world leadership. If the profession is to continue to flourish in Britain its practitioners must be assured of honoured status and high rewards.

102. In all professional matters Medicine is a free self-governing profession; but in terms of service and remuneration it is now largely controlled by the State. To allow deterioration in the standard of living of doctors will provoke dissatisfaction in the profession, will lead to a lowering of the standard of professional work and of future recruits to the profession, and will with great certainty damage British Medicine as a whole, so that the community will be the ultimate sufferer.

103. This is the main consideration of which account ought to be taken in discussions about medical remuneration, and it is the main tenet of the College in this memorandum.

104. Among more detailed considerations the College observes that since the period studied by the Spens Committee the training period for doctors up to medical registration has been extended by two years (one year added to the Academic Curriculum and one year of post-graduate hospital service). The specialist training period for Surgery has also been extended beyond the Spens Committee's allowance of six years, to the present-day usage of ten years (both excluding National Service). These alterations since the "Spens era" should be taken into account in interpreting the present-day applications of the Spens' report.

105. The surgeon's equipment, necessary for the appropriate performance of his duties—motor-car, telephone, etc.—are expensive to maintain. The maintenance of his mental equipment—learned societies, books, journals, travel, etc.—is also expensive. The College considers that such should be recognised as necessary professional expenses. The College notes that the allocations provided by the National Health Service for "study leave" for surgeons and surgical trainees, fall far short of reasonable requirements; and it suggests that such allocations should be greatly augmented.

106. The College observes that in pursuit of their professional appointments doctors during their post-graduate general training period, specialists during their special training period, and, to a lesser extent, established specialists, may have to move their homes often at considerable financial sacrifice. It suggests that the expense of moving house should be subsidised when it is incurred as a necessary professional expense.

Question 18

"Specific proposals for medical remuneration."

107. The College holds that the remuneration of the medical profession should be reviewed in the light of the Spens Report recommendations, which it considers as in the nature of an agreement between the State and the Profession; and that the terms of agreement should in general be implemented in terms of the altered value of money today.

108. The College suggests half-yearly increments in House Officers' salaries up to six half-year post-graduate periods; and that these salaries should be related to those in other branches of Medicine open to men about this stage. It suggests a "home-moving" subsidy. It suggests a streamlining of medical remuneration in respect of such items as board and lodging charges. It suggests recognition of the special professional expenses of medical men. It suggests the upward extension of annual salary increments of Senior Registrars; and the virtual abolition of less-than-maximum part-time consultant salaries. It suggests special compensatory superannuation of certain pre-war hospital consultants. It suggests that there should be

an increase in the total allocation for surgery, so as to allow expansion of the surgical consultant establishment and improvement in the remuneration of surgeons.

109. The College does not propose, in this document, to suggest specific individual salaries or allowances. It is a member of the Joint Consultants' Committee of the British Medical Association and of Royal Medical and Surgical Corporations. It prefers to make its proposals on these matters through that body in concert with its professional allies.

Question 20

"Proposals for specific machinery or procedures to be established for dealing with future discussions on medical remuneration."

110. The College notes with concern the failure of the present machinery, and in particular the lack of success of the Medical Whitley Councils. The "management sides" of them have not been free agents capable of free discussion or negotiation because they are subject to political and to Treasury control.

111. The profession's negotiating committees have fared little better, because they have attempted to negotiate with a politically-controlled Government Department.

112. The College recalls that the nationalisation of Medicine is a difficult and novel experiment, in which to date the negotiating methods have been singularly ill-adapted. It is recognised that, with the rest of the community, Medicine must evolve with the times—must change gradually and in conformity with national trends; but its traditions and practice should be disturbed as little as possible, and its terms of service should not be decided by the present unsatisfactory procedure.

113. The College feels that in furtherance of these aims it is essential that a standing neutral and non-political body should be interposed between the Medical Profession and the Government Departments concerned. The members of such a neutral body should be selected after consultation with the Government Departments concerned and with representatives of the Medical Profession; they should not be members of either. Such a body should have opportunities to consult with the Profession on the one hand, and to advise the Government on the other. It should have the duty of reviewing medical remuneration at suitable intervals; and of advising the Profession and the Government impartially on these occasions. Under its auspices Tribunals could be developed to supervise the day-to-day financial arrangements of the several branches of Medicine. The College considers that all salaried branches of the Medical Profession should come within the purview of the neutral body, including not only those in the National Health Service, but also those in the employment of Local Authorities, the Universities, Industry and the Armed Forces.

Question 21

"Any factors other than remuneration which are affecting the contentment"—of Surgeons.

114. The College takes the liberty of pursuing this point only in relation to Surgeons. It has pointed out that Surgeons are human and desire to be adequately remunerated; but it stresses that they have other desires and aspirations.

(1) Surgeons are Over-worked

115. The College has observed that most surgeons at present are severely over-worked. This impairs their practical performance; and it also impairs their ability to improve their knowledge, skill and methods; and it also impairs their ability to engage in clinical or laboratory research. It views this state of affairs with great concern—bound up, as it so clearly is, with an efficient and improving service, and with the prestige of British Medicine. The remedy appears to lie in an increase in the surgical consultant establishment; and also in the provision for research facilities in, and associated with, hospitals.

(2) Hospital Accommodation for Surgery

116. The College views with disquiet the failure to provide adequate working facilities for Surgeons. The hospitals of Britain now compare very unfavourably with those of many Continental countries and of the Americas. This is especially evident in respect of surgical facilities. It is not to be supposed that a high level of surgical service, nor in the long-run a high level of surgical skill, can be maintained indefinitely in antiquated hospitals. The allocation of substantial funds to the hospital branch of Medicine for the purpose of building new hospitals is vitally important.

(3) Hospital Administration is Often Frustrating

117. The College has noted the difficulty and frustration encountered by Surgeons in having their requests for improved facilities—even minor ones—attended to. It notes that this is bound up with ill-adapted methods of bureaucratic administration prevalent in National Health Service-controlled Hospitals. It considers that the administration of hospitals could and should be improved.

(4) There is Deterioration in the Doctor-Patient Relationship

118. The College observes a deterioration in the doctor-patient relationship, notably since 1948. There has developed a tendency to regard doctors as "servants of the State" and indeed as servants of the patient. It is an attitude of mind that gives rise to undesirable litigation on medical issues, although the College is by no means opposed to proper and genuine discipline of the profession by this and other means.

Remuneration of Dental Surgeons

119. The College has had the privilege of scrutinising the "Report of the British Dental Association to the Royal Commission" (1957), and the "Evidence submitted by the Council of the Royal College of Surgeons of England to the Royal Commission on Doctors' and Dentists' Remuneration—Part B—Dental Surgery" (November, 1957). On behalf of its Fellows in Dental Surgery it desires to endorse the terms of these documents.

SUMMARY

120. The Royal College of Surgeons of Edinburgh considers that the high level of service and of world prestige of British Medicine and British Surgery must be maintained.

121. It notes that the Welfare State has eased the lot of the poorer medical students; and, through its National Health Service, has improved the economic position of newly qualified doctors; and provided a measure of security, though at a depressed level, for most of the profession.

122. Nevertheless, through the operation of the National Health Service the State has rendered Medicine a less attractive profession, with distinct trends towards a levelling mediocrity and an impairment of the spirit of adventure and other incentives to high endeavour. It has caused considerable depression in the profession's economic status by failure to adjust the remuneration of doctors to the cost of living. It is responsible for certain anomalies of remuneration that cause serious financial hardship. Its operation has occasioned an impairment of professional dignity and a deterioration in the doctor-patient relationship, and of the profession-public relationship by undesirable and publicised disputes upon remuneration and similar matters; and it has undermined the stability of the profession by subjecting it to the disturbance of frequent disagreements about terms of service.

123. It suggests that these ills could be removed or alleviated by the following measures:—

- (1) An upward adjustment of medical salaries generally in conformity with the increased cost of living;
- (2) The removal of existing anomalies of remuneration that cause hardship;
- (3) The recognition of reasonable medical expenses allowances;

- (4) Compensation for the recent increase in the duration of medical training ;
- (5) Streamlining of financial relationships between the Health Service and the doctor to suit the convenience of a learned profession ;
- (6) Restoration of the spirit of adventure and enterprise by encouraging private enterprise in practice, research and teaching, and by restoring, and even augmenting, the value and the peaks of merit awards ;
- (7) Increase in the establishment of surgical consultants to alleviate overwork ;
- (8) The replacement of deteriorating surgical facilities by new hospital building and equipment.

124. The College holds that medical remuneration should be removed from the disturbing influences of politically controlled Government Departments by the interposition, between the Government Departments concerned and the Profession, of a Neutral and Independent Body whose duty would be to regularly scrutinise medical remuneration and to keep it in conformity with future times.

125. The College observes with pride that the Medical Profession has exhibited a notable degree of restraint in applying for remedies for the several impairments that have come upon it. For example, it believes that few vocational groups would have tolerated so uncomplainingly the failure to maintain agreed basic medical remuneration in conformity with the cost of living, and of the payment of agreed merit awards in 1958 at the 1939 values.

Examination of Witnesses

PROFESSOR JOHN BRUCE (*President*)

PROFESSOR N. M. DOTT (*Vice President*)

MR. J. J. MASON BROWN (*Treasurer*)

on behalf of the Royal College of Surgeons, Edinburgh

called and examined

2666. *Chairman*: Professor Bruce, you are acting as the primary spokesman of the Royal College are you?—*Professor Bruce*: Yes, Sir.

2667. We have, as you know, only received your evidence in proof form a few days ago, and we have numbered the paragraphs in it.—May I apologise for the late arrival of our memorandum? This was due to a change in secretaries and to illness ; also I was in America. That explains why we have been apparently so discourteous. I would like to take the opportunity of saying how sorry we are.

2668. I do not think it necessary for you to apologise ; we appreciate the reason for the delay, but it has meant of course that we have not been quite able to give as complete a study to the document as we have with some others.

We may of course want to ask you questions on other matters, not just on your own evidence, and you must not imagine that in putting any questions

there is any hostility on our part. If we do not ask these questions no one else will. On the other hand there are some things you do say that we probably will not deal with, and we do not want you to think this is because they do not seem important to us, but because they have been dealt with by other bodies. Just to start, I think you do tell us at the beginning about the status and government of the College, but I wonder if just for the record you would give a brief outline of who you are.—The Royal College of Surgeons of Edinburgh was first incorporated in the year 1505. Since then we have been responsible for the education and examination of those who are aspiring to become surgeons. We consist of a large number of surgeons both at home and abroad ; we have a total of 3,371 Fellows, of which 1,735 are resident in the United Kingdom. Those Fellows by vote elect a Council of the College and office bearers, so that we three, myself the President, Professor Dott the

Vice President and Mr. Mason Brown the Treasurer can, I think, claim to speak for the body of Fellows since we are elected office bearers by an elected Council. We still, by means of our examinations, by means of our courses of instruction, play a considerable part in the training of surgeons, and our Fellowship is recognised as one of the accepted criteria for access to a consultant post in the National Health Service. We are independent guardians of the standard—one of the guardians of the standard—of surgery practised in the United Kingdom, and indeed in most of the Commonwealth countries.

2669. *Sir Hugh Watson*: It is right, Professor Bruce, that your College speaks mainly for the consultants?—Yes, but I suppose also senior registrars and other grades, employees in hospitals and in the National Health Service.

2670. Looking at your paragraph 8, in which you remark on the "steady and apparently relentless depression of the social and economic status of the doctor that has occurred since 1948". Representing, as you do, largely consultants and registrars, in what respect do you consider the social status of your members has been depressed since 1948?—I think the members of the consultant profession, certain sections of them, are unable to travel abroad, for example, as they did before; many of them have been unable to send their children to the type of school they went to themselves; many of them have to move into smaller houses, for example. Over all there has been a general deterioration in their social status.

2671. Do you think that has manifested itself among the ranks of your profession to a greater degree than other comparable professions?—I would not know about that. I am convinced that it is so in our own profession.

2672. You are taking it absolutely; you have not considered it relatively to other professions?—I have not.

2673. What the Commission have in mind is that this sort of thing is going on all round; one sees it every day, as you know.—It has, I think, been particularly marked in our profession.

2674. *Chairman*: You did speak about them having to move into smaller houses.—Yes, and schooling for example is a very important matter.

Several of our members have been unable to give their children the same kind of education as they got themselves.

2675. *Sir David Hughes Parry*: You have fixed on the year 1948 when this started. Would you say that was associated with the National Health Service?—Yes, Sir; it was really then that generally the remuneration of consultants was fixed.

2676. Do you not think it could have been a consequence of the war rather than merely since 1948?

Chairman: And a consequence of taxation?—Yes, I think that has definitely affected it. But on the other hand there has been a deterioration in remuneration of the surgeons concerned since the introduction of the National Health Service; so if 1948 is not the entire cause, it is at least a contributing factor.

2677. *Sir David Hughes Parry*: The implication of what you say is that it is the effect of the National Health Service rather than what happened in the years 1939 to 1945?—*Professor Doit*: Further on in our memorandum, in paragraph 99, under the heading of "Superannuation" we do recognise that the war played a part.

2678. *Sir Hugh Watson*: That section deals with superannuation and retirement; it is rather a different chapter?—Yes.

2679. At all events the view of your College is that as a result of the way in which consultants have been dealt with under the National Health Service there has been a deterioration in their financial position which has affected their social status. You mentioned as an indication that some of them have had to move into smaller houses, and that they cannot afford to send their children to public schools; and the Chairman made the point that taxation might come into it to a considerable extent?—*Professor Bruce*: Yes, it does. There is also the point that they cannot move about with the freedom they were accustomed to for professional purposes. It is with greatest difficulty that younger surgeons go to America for professional purposes, which is a very laudable thing from the point of view of British medicine; it is with great difficulty that they can do these things at all now. Before the war they did not occasion very much difficulty.

2680. On the question of going to America, is that because they cannot afford to go?—Yes.

2681. Are there not a number of cases in which, by one means or another, grants are made available to persons in professions to visit other countries?—Yes, there are; but they are not very plentiful. The National Health Service itself make that sort of grant, and there are other bodies, Rockefeller, the Commonwealth Fund, Fulbright, which do make it possible. But the opportunities are not nearly as great as they were before.

2682. *Chairman*: Is that again not common to all walks of life, that there is much greater expense attached to living now?—I think it may quite well be so, Sir.

2683. *Sir David Hughes Parry*: There are more grants available for this purpose now, much more than before?—I think that is true, Sir, yes. I would not say much more, because when you are trying to help somebody to go you find it is very difficult to find an appropriate fund.

2684. *Sir Hugh Watson*: Was there a large traffic to the United States for instructional purposes and general enlarging of views before the war?—Yes, quite a lot.

2685. As the Chairman points out, that has become much more expensive now, especially in view of the dollar exchange and the high cost of both sea and air passages.—Yes.

2686. *Mr. Gunlake*: Is there a distinction between full-time consultants and part-time consultants in this respect, in that the latter can apply for certain tax reliefs?—If he is giving a lecture or two in America, for which he receives remuneration.

2687. That is more difficult for the full-time man?—That is more difficult, yes.

2688. *Sir Hugh Watson*: Supposing there was a conference in Stockholm about investigating methods of relieving cancer, would people going from this country to such a conference—part-time consultants as Mr. Gunlake asks—be entitled to tax relief for such a conference even if they were not delivering papers?—No.—*Professor Dott*: That has varied a good deal from time to time

in different regions, this tax relief on such missions; sometimes it is granted and sometimes refused.

2689. *Chairman*: Would you say there is less travel now, not merely to the United States but, for instance, to Scandinavia, Holland and other places overseas?—*Professor Bruce*: There is still a fair amount; people do struggle to go, but it is very often a struggle, and very often somebody has to deny himself the opportunity because he cannot afford it. In the long run I would not say there is very much difference in the total number of people travelling, but it is very much more difficult for them to go.

2690. *Sir Hugh Watson*: We would like you to deal with this as fully as you want to. These are the principal respects in which you feel the social status and the general position of consultants has been adversely affected?—Yes.—*Professor Dott*: I would like to add that travel even within the United Kingdom has become difficult and impeded by the social depression.

2691. Which is it? Professor Bruce says the inability to travel is caused by the economic depression, and now you say travel is impeded by the social depression.—I should have said the economic depression. It has been quite noticeable that members of important specialist societies and so on, have had to cut down their attendances at meetings of those societies because of poverty.

2692. I think it is fair to say that most of us here who have to go to London under our own steam travel second class. I think that is a general matter, Professor Dott, is it not?—It certainly is, but I would have judged it affects the medical profession rather more than others.

2693. I would rather like to find out on what you base that view. It is quite understandable, but I think the Commission would like to know why you feel the medical profession has been so much worse hit than any other professional class.—I am afraid one can only say it is an impression, and it is also an impression of many of my colleagues.

2694. *Mr. Gunlake*: Would it be fair to say that some of the other professions have been at liberty to increase their charges?—*Sir Hugh Watson*: That would affect only the whole-time consultant, not the part-time consultant who is at liberty to charge such fees for his private work as he feels appropriate.—

Professor Bruce: The fees which are charged by the profession are substantially what they were in 1939; the cost of an operation, the cost of a consultation is, I should think, substantially what it was in 1939.

2695. *Professor Jewkes:* What about the scale of private practice? Is not the amount of private practice decreasing?—It has decreased enormously in Scotland and in Edinburgh. Eleven private nursing homes which were functioning in 1939 have closed down since the end of the war and only one new nursing home has opened up, so there is a net loss of ten nursing homes. In fact there are only four nursing homes in Edinburgh in which it is possible to do private operations. That represents an enormous decrease in the volume of private practice, in a capital city.

2696. *Sir Hugh Watson:* Are there not in the hospitals in Edinburgh any paid beds?—There are no paid beds.

2697. *Professor Jewkes:* We have been told in England that these voluntary associations may at least help to maintain private practice. Does that not operate in Scotland to the same degree?—It is operating in Scotland, and I think it will tend to maintain private practice where it can function, but it can never function in relation to surgery if there are no places in which the work can be carried out. The great shortage of surgical nursing home facilities and the complete absence of private pay-bed accommodation in hospitals makes it very difficult.

2698. *Chairman:* Have you any idea of the proportion of consultants in Scotland who are part-time? Is it vastly different from the proportion of part-time to whole-time in England?—The majority in Scotland, the large majority, are part-time.

2699. They carry out part of their work outside the service?—Yes. In Glasgow I think at least one or perhaps two of the Glasgow hospitals have private annexes, just as they have in the London hospitals; but Edinburgh has never had these. I do not blame the service for that, because the premises just were not there to be taken over, and it has not been possible to provide funds.

2700. *Sir Hugh Watson:* Have you any observation to make about the hospital accommodation in Scotland generally, as

compared with elsewhere?—We are very depressed about the quality of hospital accommodation in Scotland, compared with the Continent and Canada and the United States of America. Our hospitals are old, and were built before medicine had become really scientific, and it has not been possible in these old buildings to provide the ancillary services which are fundamental now to modern scientific practice of medicine and surgery. On that account we suffer very badly. I have just come back from a visit to the United States and Canada. Their hospitals have proper facilities for the scientific investigation of disease; then you come back here to a hospital where these facilities do not exist. We really need a very extensive hospital building programme if our hospitals are going to be in any way comparable to those of Scandinavia, Western Germany, Canada, the United States and Switzerland, which are the five countries I happen to know about particularly.

2701. In the next paragraph you suggest that "new and more liberal methods of administration are necessary if the experiment [of the National Health Service] is to be a successful one." That infers some criticism of the administration, and the Commission would like to know what you have in mind generally.—*Professor Dott* will speak about that.—*Professor Dott:* The most important thing we had in mind is given at the end of our evidence, and that is we feel the need for independent professional bodies.

2702. Is that with regard to the question of remuneration?—Yes.

Sir Hugh Watson: I thought this sentence was directed at something different, but if I am wrong we can leave it at that.

2703. *Professor Jewkes:* There is no suggestion that the actual administration of the Health Service should be modified in any way? You are thinking mainly of a change in the body that would first deal with the question of remuneration?

—*Professor Bruce:* We have in mind also that there are a lot of little frustrating and annoying things which happen, and which are tedious to the members of our profession. The kind of thing such as being refused permission to go off to a conference, for example. Sometimes there are tedious relationships with boards of management in connection with getting equipment; there are delays

and so on, which I think a more enlightened medical administration would avoid.

2704. *Chairman*: A more enlightened administration, or more enlightened methods?—I suppose it is hard to define what I mean. Since the start of the National Health Service the profession itself has had singularly little say in how the service should develop. There has been, until very recently, no real mechanism for consulting the people who are actually working in the hospital about hospital policy or hospital development. I think from the start there should have been some kind of proper consultative machinery with the actual members of the hospital staff who were working in the hospital and whose main interest is in the hospital, and who are even more jealous than any boards of management for its good name and its success. It is things like that we had in mind.

2705. *Mr. Watson*: On that particular field would you put new equipment and new hospitals before remuneration?—That is a very difficult question to answer. If you are asking me personally I would say yes, but speaking as the President of the College of Surgeons, I dare not.

2706. *Professor Jewkes*: Might I ask whether one possible answer to that question is both remuneration and capital equipment for your hospitals; you do not rule that out as a possibility?—No.

2707. *Sir Hugh Watson*: Your feeling is that there is a certain amount of frustration and petty restriction and so on but this, for all you know, may stem from lack of funds.—It is not all lack of funds. I have never experienced this myself, and I do not know if my colleagues here have experienced it, but in some hospitals we do know there have been attempts made to make them sign their name in the morning with the hour they come in to work. Those are degrading little things for somebody like a consultant surgeon; they are petty-fogging little restrictions—things like charging for a cup of tea after an operation. After you have finished an operation and want a cup of tea to replace your fluid loss, they charge 3d. for it.

2708. Most of you should know that the normal charge for a cup of tea anywhere else is 6d.—It can be curiously circumvented in any well-run organisation.

2709. *Chairman*: In this paragraph about new and more liberal methods, you are dealing with the hospital side rather than with general practice?—Yes, Sir.—*Mr. Mason Brown*: Might I give an example from my own hospital? Before the service was introduced it was my duty as the senior surgeon to report to the board of management each year, and to report what was likely to be needed in the way of equipment. Since the Health Service no such advisory report has been requested and when one was presented it was flatly turned down. When you put in for equipment there is no money for it. A month ago at a meeting we had to delete necessary items and put them in priorities because there was no money. And yet a month later, at the next meeting of the committee, they had found there was more money than they thought, and they then had to find items which we could buy before 31st March in order that the money should be used. It is that sort of administration which is infuriating in running a hospital.

Sir Hugh Watson: I thought that was the sort of thing Professor Bruce had in mind; I am glad you mentioned this.

2710. *Chairman*: In the days of the voluntary hospitals there was not always unlimited money.—No, but they were always willing to make a special appeal for money, or to put some money aside in order that the hospital could be kept up to date.—*Professor Bruce*: What happened then was that if you wanted a new piece of equipment you asked the Superintendent and you got it. Now it is extremely difficult; priorities are put up all over the place, and it may be many months before items of equipment become available.

2711. *Mr. Bonham-Carter*: Do the hospitals work on a budget system, anticipating expenditure for a period ahead?—I do not know how they do it. I suppose they must.

2712. *Mr. Watson*: Would it not be fair to say, leaving out of account the standard of hospital buildings, that our hospitals are better equipped now than before the Health Service?—I would not have said so. I think there has been an upgrading of the poorer hospitals, but in the major teaching hospitals I do not think that is so at all. There is improved equipment, of course, because improved equipment is used in surgery nowadays; it would be very difficult for a surgeon

who practised in 1935 to recognise the hospital he worked in today. But that has not come about through any fundamental improvement brought about by the Health Service. These are the advances in scientific equipment and engineering.

2713. *Chairman*: Has there not been more money spent in hospitals, taking the country as a whole, than there ever has been before?—I think that is quite true.

2714. *Sir David Hughes Parry*: You mentioned the buildings were old; but is it not the case that in that respect since 1948 there was a lot of leeway to be made up? It seems that you were comparing the good old days with the rather bad days which have come about, and yet you admit that there was a good deal of leeway to make up from the good old days.—Yes.

2715. *Professor Jewkes*: You compare the position in British hospitals with the position in hospitals in the United States, Scandinavia, etc., to our disadvantage. In what way are these overseas hospitals superior? You suggested there is new equipment in these hospitals, that somewhere we are lagging behind. Could you amplify that?—Yes. I do not know where to start. The problem of investigation of disease now means space for laboratories and scientific work, and in most hospitals, wards are well supported by ancillary laboratory accommodation in which the studies of the patients can be made. Advantage has been taken in most of the hospitals of the various methods of ventilation, so that the standard of safety in the actual conduct of surgical work is greater than in this country. The wards of our hospitals are generally large wards, public wards, as in the case of my own, with 30 patients lying side by side. In these Scandinavian and American hospitals they are working up the small four bed wards and single rooms, where a person can die in privacy, or where his relatives can at least be grief-stricken in privacy, and not in a large ward. These are some of the ways in which we are lagging behind. In the teaching hospitals we lag behind in the very inadequate provision which is made for the teaching of students. In a great hospital like the Edinburgh Royal Infirmary—before the National Health Service perhaps the largest voluntary hospital in this country

—the facilities we have for teaching students are quite appalling compared with those of Scandinavian hospitals.

2716. *Chairman*: Were we already in many of those respects lagging behind in 1948?—Yes, Sir. But it is very striking, if you have been in Scandinavia or Canada recently, to see the amount of new hospital building going on—Toronto, Edmonton, Calgary, Vancouver; in all these places there is a very vigorous new hospital building programme. Then there is the new Veterans' Hospital in Toronto, a magnificent hospital, built by the state of Canada as part of their veterans' scheme; and the new Montreal General Hospital, which is a very fine hospital, built entirely by voluntary subscription.

2717. *Mr. Watson*: I am rather interested in this remark that in Edinburgh you have deplorable equipment. In paragraph 3 of your memorandum, in which you deal with the three Royal Surgical Incorporations of England, of Glasgow and of Edinburgh, you go on to say that such is the prestige of these Fellowships that they are regarded overseas as a hallmark of sound surgical education.—Yes, Sir.

2718. Is that a statement of fact?—Yes, Sir.

2719. *Professor Jewkes*: Has there been no new hospital built in Great Britain since 1945?—I think there is one in the west of Scotland, in the Vale of Leven, and I know St. James's at Balham have had a new wing. I do not know of any other, and I certainly know of no general hospital which has been built.

Mr. Bonham-Carter: I am sure there must be, in some of the new towns—in Crawley, for example.

2720. *Professor Jewkes*: The statement was made in 1954 that no new hospital had been built in Great Britain since the end of the war, but since then there may have been.—I think if there had been we would have heard about it.

2721. *Chairman*: And you heard of the one in Scotland, in the Vale of Leven?—I do not know whether it was built before 1954 or not.

2722. It was since the war?—Yes; but that was built, I understand, for a special purpose. I may be wrong. It

was not really built specifically as a contribution to the hospital problem, but with some other national function in mind.

2723. *Sir Hugh Watson*: Shall we pass to another topic? You are familiar with the terms of reference of this Royal Commission, and you know the terms of reference are to consider how the levels of professional remuneration in the National Health Service compare with those outside in other professions, and to make recommendations in the usual way. This Commission has said it will pay attention to the Spens Reports, both the consultants' report and the others. In paragraph 12 you have stated your view that the succeeding Government, the Government succeeding to that of the Attlee Government in 1950, has failed to uphold the undertakings of its predecessor and to honour its moral obligation to the profession. I take it you are aware that view is not shared by the Government?—Yes; I would not expect the Government to share that view.

2724. And further on you say your view is this failure constitutes a breach of faith. Again you would appreciate that there is another view about that matter. That is your view?—Yes, Sir; but it seems to me relatively simple to resolve this. When in 1948 we were invited to join the National Health Service I took some part in the negotiations as a member of the general committee, and with Sir Henry Wade we took upon ourselves the responsibility of advising our consultant colleagues to agree to enter the National Health Service because the Government of that day accepted the principle of the Spens Report, a fundamental part of which concerned remuneration. It seemed to me it was a very clear statement that they accepted the Spens Report, and it seems to us that, since then, the present Government have been unwilling to face up to the repercussions of the Spens Report.

2725. That is why this Royal Commission has in fact been set up?—Yes.

2726. I think perhaps we can leave it at that for the moment. I can assure you that the Commission will have the terms of the Spens Report in view. But you appreciate the remit of this Commission is to make up its own mind as to what is the appropriate level of

medical remuneration in the Health Service.

In paragraph 16 you express concern about the overall number applying for medical training; you say that is slightly falling, and that there is a considerable proportion of unsatisfactory entrants. In what respect are they unsatisfactory?—That is answered elsewhere. There is a very considerable wastage rate, 21.5 per cent., I think in our own University. That means that one out of every five proves to be unsatisfactory.

2727. Can you tell us what was the wastage rate before the war?—I cannot give it in figures, but it was very much less.

2728. *Chairman*: At what stage does most of the wastage occur?—In the first two years.

2729. Through failure to reach the required standard?—Yes.

2730. As tested by examination?—Yes, as tested by examination.

2731. *Sir David Hughes Parry*: Do you think that is because there is a failing in the process of selection used?—There must be; we must be failing on a 20 per cent. basis. But in our own University the students are interviewed, they must have obtained certain scholastic standards; we grade them according to their scholastic record, and we have references from distinguished headmasters and others. You would say that overall the thing was almost infallible, and yet we prove to be wrong in 20 per cent. of the cases. Before the war selection was not so necessary; there were not the number of medical students. There were only 98 in my year as opposed to the large numbers we have now. The numbers are falling off, not so much as compared with before the war as with the few years around 1948. Fewer parents could afford to put their children through medical school before the war.

2732. You took fewer students at that time?—At that time fewer were applying.

2733. And fewer were taken in?—Yes, fewer were taken in.

2734. It may be that too many are now taken in?—We think in some schools anyway there should be a reduction in numbers.

2735. *Chairman*: Is it necessarily a bad thing to start off with rather more than you finish up with, in order to get a selection?—It is not altogether a bad thing in some cases; but if you consider the expense of the teachers' time and the limited laboratory and classroom accommodation, then it is a great waste to take people for two years and have them fail at the end. If by some other means of selection you can attract a higher standard of entrants and eliminate that wastage—that would be a much better proposition.

2736. *Mr. Bonham-Carter*: Is one in five a very high rate of failure? Have you got anything with which you can compare it?—I do not know what you could have to compare it with.

2737. I can see why you feel like that about it, but I wonder if you have any experience in other fields against which you could measure it?—No, Sir; I have not any experience.—*Professor Dott*: I think our point mainly is that of those applying to enter as medical students, you select about one in five, and we think with that selection we ought to be able to secure that a higher standard is accepted.

2738. *Chairman*: You said you select one in five?—Yes, of the applicants.

2739. There are five times as many people who would like to become doctors as you will take; and of those you take four-fifths are satisfactory and one-fifth turn out to be not quite up to the standard.—That is correct.—*Professor Bruce*: I would not like my diagnoses in other things to be wrong in 20 per cent. of cases.

Mr. Bonham-Carter: That is why you have got it pretty high. I can tell you that in at least one profession one in three is regarded as good at the first point—after that I cannot quite say.

2740. *Sir David Hughes Parry*: It is difficult, because you are now entering on a non-school subject. It is easier to select people for classics and things of that nature.—Yes, I should say that.

2741. *Mr. McIntosh*: I would like to be clear about this. Do you feel there may be something wrong with your method of selection in that you may be turning away one or two who may be quite satisfactory, or is it that you feel the general quality of applicant is not as good?—I think it may be a little

of both. It is a very hard thing to be dogmatic about it, but it is our impression that the average quality is not as good as it was before.

2742. *Chairman*: What proportion of applicants used you to accept before the war, have you any idea? Have you very many more applicants now than you had then?—Yes, Sir.

2743. Why is that? Why are more people wanting to be doctors now?—It always has been that in wartime and immediately after war, there is a very considerable increased demand for entrance into a University. You have fellows coming back from the army and a great mass of people wanting a University education of some kind, and medicine shares in that increase in the University population.

2744. *Mr. Bonham-Carter*: In England one answer to that question would surely be that the 1944 Education Act opened the doors to much larger numbers of candidates. I understand the educational grant system in Scotland is rather different. Has there been that same widening of opportunity that one has in England?—Yes.—*Professor Dott*: About 60 per cent. of our students are in receipt of grants.

2745. *Chairman*: What really matters is whether the quality of those candidates you accept is lower or higher, or the same as before, particularly bearing in mind that you are going to get a good many more than you used to do. What is the answer to that one?—*Professor Bruce*: Our impression is that the quality of the average student is not as high as it was.

2746. The average you accept and depend on to pass?—Yes.

2747. *Sir Hugh Watson*: Do you think that has anything to do with the very wide extent to which the doors of Universities have been opened to people who previously could not afford to come in—in other words, the extensive system of grants?—I think that has something to do with it.

2748. *Chairman*: On this question of quality, do you imply that some of those who would have become doctors, some of the better top quality men, are now going into other professions?—Yes.

2749. Is that partly because, as we were told yesterday, of the attraction of

science, the propaganda in favour of scientists? Some of them are being drawn by that?—I think they are attracted, that is natural; but also some who would I think be very obvious applicants for entrance to medicine are now going into industry, accountancy, and into law. We all know sons and daughters of friends who have deliberately forsaken medicine after generations, for some other profession.

2750. *Sir Hugh Watson*: In regard to this tendency for a decline in the number of people seeking admission to the profession, you mentioned law. In point of fact, the intake into the legal profession in Scotland last year was exactly half what it was five years ago. We have evidence of this all round, you see.—I accept that, of course, but I was really thinking in terms of quality. I think there is a smaller proportion of the type of person who used to go into medicine coming into medicine now.

2751. *Professor Jewkes*: Could I ask a question on the matter of numbers? There may be many other reasons why the number of people applying for medicine is falling, but we have not got the figures here. One possibility perhaps is this, and I wonder what you think about it. Boys and girls who are reaching the age of 18 now were born in 1940, and between the years of 1935 and 1940 the birth rate was abnormally low. So that in fact in the last four or five years there have been a relatively smaller number of people available for going into professions, whether you are thinking of one faculty or another. So it may very well be that this decline you notice in applications for medicine is to do with the reduction in the birth rate 18 years ago. Conversely of course the bulge in the birth rate after the war will later react on the numbers entering Universities.—*Professor Dott*: It is not a numerical decline.

2752. *Chairman*: You are in fact getting more than you were before the war?—Yes, more than before the war.

2753. But you are rejecting a much higher proportion?—Yes, we started off just after the war with something like 1,500 applicants, and it is now 750; there is still a decline.

2754. And before the war it was about how many?—*Professor Bruce*: It was very much less.

Chairman: Well below 750?

2755. *Sir Hugh Watson*: The Royal College of Physicians of Edinburgh have given us some figures. In 1938-39 there were 521 applications to enter the medical faculty of Edinburgh University; in 1956-57 there were 769 applications.—Yes.

2756. You go on to suggest in paragraph 17 the reasons why the quality is falling off. You say it is because of the curtailment of freedom, the disappearance of incentives, and the increased duration of successive training periods. Do you think these really deter young men from going into the profession, that they have got to undergo longer training?—Yes, Sir.

2757. Whether or not you think there has been any deterioration in the quality of students coming forward, do you think there has been any striking change in the professional ability of the newly qualified doctor?—Not yet.

2758. Would you say that owing to his longer training he is probably better trained now than he was before?—I would not like to say because of the longer training. I think we make the point later that the training is too long as it is.

2759. Other people suggest that he is better trained and better equipped because of his extra pre-registration year. You offer some criticisms in paragraph 19 about the tendency of the young to insist on their rights. That is general in the young today—it is not confined to the medical profession?—Yes, I have a note here "not peculiar to medicine."

Sir David Hughes Parry: Nor to the young.

2760. *Mr. Bonham-Carter*: On this question about the curtailment of freedom, I wonder if that is a matter of age too. Do you not think that people who were in a profession such as yours before the war may fear this curtailment of freedom considerably, whereas younger people who have grown up in the modern world do not bother much about it?—That may be true.

2761. Perhaps this feeling is not quite as strong as you suggest in this context.—Yes, I think that is so. We feel it perhaps more, being brought up in a different period.

2762. *Sir Hugh Watson*: There is the question of training grants which you deal with in paragraphs 24 and 25. You point out that there is a certain inequality between English grants and Scottish grants. The English recipient in fact gets little more than the Scottish recipient. Also you point out that there may be an unwillingness on the part of English Local Authorities to give grants to students attending Scottish Universities, because in certain circumstances they may have to spend a year longer in the University. Steps have been taken in Scotland to remedy that, and opportunities are being given to students to sit at the University for examination on subjects which are at present dealt with at the end of the first year, straight from school.—Yes, Sir; it has not got quite to the stage of being a fait accompli. There has got to be a University ordinance to that effect, which has still to be negotiated.

2763. It is on the way?—Some steps have been taken towards it, but I do not know whether it is going to be successful or not.

2764. *Sir David Hughes Parry*: When did the extension of the period from five to six years occur?—In 1953.

2765. Who was responsible? Who made the decision?—The General Medical Council were the responsible body.

2766. The University Grants Committee at the time were opposed to an extension because of the expense to the community?—We say we think it is too long a period to pay a training grant.

2767. *Professor Jewkes*: I wonder if you could tell us what are the disadvantages of six years as against five years?—It is a long time to spend in the course of training, especially when it is added to by a forced pre-registration year—then it means seven years, and that is a very long time.

2768. Is the time spent on clinical work?—It is almost entirely spent on pre-clinical work.

2769. *Mr. Gunlake*: It has been put to us that the effect of increasing the period from five to six years might be that the young man does not have to work quite so hard. Would you agree?—No, he is much harder worked.

2770. *Chairman*: Could he do it in five years without undue hard work?—Yes, I am quite certain of that.

2771. *Professor Jewkes*: Would he have to work harder if it was five years instead of six, or do I misunderstand you?—I think obviously he would learn a good deal quicker.

2772. *Sir Hugh Watson*: You think that five years would probably be quite long enough?—I do.

2773. In paragraph 30 you criticise as a minor point, as a pinprick, this question of the young men being charged for lodgings where they are resident in hospital, and particularly when they are charged even if they are away. You know these figures were agreed at the Whitley Council, and you know they are fixed on an annual basis and that they represent substantially less than the actual cost of the services provided?—Yes, Sir.

2774. Would you agree it is not unreasonable for some charge to be made for such services, and that it should be taken into account in some way in fixing the remuneration of the young doctor?—Yes, Sir, that is seen. But what we do suggest is that this should not come as a deduction from the salary, but that it should be adjusted before their salary is agreed upon.

2775. In other words, you would rather reduce the salary somewhat and give them free board and lodging?—Yes. This problem has occasioned great resentment, because the standard of board and lodging varies so enormously, the quality of food varies so enormously from hospital to hospital. And the young men do not readily understand why, if they go away for their holidays and their locum comes in and is charged, they should pay the charge as well. It is difficult to see or explain. This could be eliminated by having board and lodging incorporated into their salary.

2776. *Chairman*: But there would still be the same differences in the standard of board and lodging?—There would be, but if this was not regarded as a charge against the individual it would not be so serious.

Sir David Hughes Parry: It might still be regarded as a charge for the purposes of income tax.

2777. *Mr. Bonham-Carter*: How much income tax rebate would there be?—Not very much.

Sir David Hughes Parry: It might very well be higher. The local income tax people might very easily take a higher figure than is taken now.

2778. *Chairman*: It would seem to be a psychological point. You are not really suggesting any alteration in the real situation, but merely the method.—No, it is just one of the little frustrations and annoyances that we think could be eliminated, and would make for increased happiness and increased efficiency.

2779. *Sir Hugh Watson*: It is rather comparable to the charge for cups of tea, perhaps!—It had a delightful repercussion involving one of my own house surgeons not long ago. He found he had to pay for his board and lodging on leave, and so he decided to spend his leave at the Edinburgh Festival and occupy his room; so that there was difficulty in finding somewhere to house his locum, who also was being charged for board and lodging. That kind of thing does not make for the best feeling in the service, and it could be so easily eliminated.

2780. *Chairman*: You have recently been abroad. Do you happen to know whether in other countries such as Canada, or the United States, the hospital officer is normally paid a salary and charged for his board and lodging, or whether he is normally given a smaller salary with free board and lodging?—I do not know about Canada, but I know in the United States board and lodging is included in his remuneration. He is not paid and then charged for board and lodging, but board and lodging are included in his salary.

2781. *Sir Hugh Watson*: So this pinprick is absent in the United States?—Yes.

2782. *Chairman*: May I ask a question on paragraph 31 where you say the proper adjustment is an approximation to the Spens recommendation. That was not in fact a Spens recommendation.—I do not follow.

2783. I do not think that was a Spens recommendation at all.—I apologise; I think that paragraph in fact cannot really arise.

2784. *Sir Hugh Watson*: I think the Commission would be very interested in what you have got to say about the difficult question of interchangeability. You point out in paragraph 34 that in part the difficulty is the result of failure of co-operation between the several branches of the profession itself. You say the remedy for this is in the hands of the profession. Then you make certain suggestions. Could you elaborate your views about this difficult question?—We put in this point that it is partly the result of failure in co-operation between the several branches of the profession because we want to be completely fair about this. Difficulties have been raised on the part of, for example, general practitioners, about accepting into general practice people who have spent some years in hospital. Before the war somebody who after some years was either unsuitable or unhappy in a hospital environment, or wanted something else, could get out into general practice; he could buy a practice or put his plate up, and that was quite simple. Now he has to apply for a vacancy after it has been advertised, and his application has to be considered by the Executive Council; and unfortunately there has been a tendency to turn down the man who has spent some years in hospital.

2785. For the information of the Commission, who constitutes the Executive Councils?—That is a body set up by the general practitioners' organisation.

2786. That is what I mean; there is a large medical representation on that body, is there not?—That is why we say this is partly a professional difficulty. They make the case that the man who has been some time in hospital is perhaps not such a good general practitioner as the person registered to become a trainee and then an assistant in general practice. It is a very easy case to make, initially.

2787. *Professor Jewkes*: Is there anything in it?—No, there certainly is not. The man who has had good training in hospital does not take very long to make an excellent general practitioner. Some of our best general practitioners in Scotland have spent years in the hospital service and have not gone straight from qualification into general practice.—*Professor Dott*: The converse holds to some extent. It would be more difficult for a man to get a post in the hospital

service after having done let us say three or five years in general practice.

2788. *Sir David Hughes Parry*: It would be an advantage to have done a certain amount of general practice, would it not?—In many cases, yes.

2789. What suggestions do you make in this respect?—We rather think it is an intra-professional matter. We think you perhaps could help on the financial side to aid the flow, the transition between the two sides. But we think only the profession can help itself on this matter of bridging the gulf.

2790. *Chairman*: As regards the financial side, Professor Dott, what you mean is that anybody transferring from one branch to the other at a slightly later stage than the end of the first house officer year should not be at a very great financial disadvantage. There has got to be a very fair balance struck. Now what you mean is that a balance should be struck between the senior house officer, first or second year registrar on the one hand and the man of equivalent age in general practice on the other?—Yes.

2791. Do you think that the man in the hospital service as a first year registrar is getting more than the man who has gone into general practice, or the other way round?—The other way round. He is in fact I think usually getting something between the first and second year registrar salary.

Chairman: I thought he was actually getting more.

Sir Hugh Watson: All the information we have on that is gathered from advertisements which have appeared in the medical journals. Our information is that assistantships are advertised at round about £1,050 with certain variations in the matter of car allowances and things of that sort. That is the sort of salary offered to assistants according to the information we have.

2792. *Chairman*: Of course, the trainee assistant has £850 plus a car allowance. It is not possible to be precise about this because the assistant is in contract with the principal, but it did not seem to us that there was a very wide discrepancy at that stage between the two branches. You think the general practitioner at that stage is getting a good deal more than the one who remains in hospital?—*Professor Bruce*: The regis-

tered trainee at the start gets £850. The year after that he can become an assistant at £1,000.

2793. And if he remains in the hospital service?—In the hospital service he will get a bit below that when he has just finished two years.

2794. *Sir Hugh Watson*: At that stage in the hospital service he would be a senior house officer, would he?—He would.

2795. In which case he would be getting £819 10s.?—As opposed to £1,000—not a great deal in it.

2796. *Chairman*: That is as opposed to the £850?—He can be a trainee assistant the moment he gets on to the register, of course.

2797. *Sir Hugh Watson*: He can also be an assistant, can he not?—And he can be an assistant at £1,000 a year the moment he gets on the register.

2798. *Chairman*: At any rate your view is that the people on the hospital side at 28 and 29 are earning less at this stage and would transfer with financial advantage to the general practice side. But those who go straight into general practice would suffer a financial disadvantage if they went back to the hospital side. You would like to see remuneration in those two branches somehow kept more in line for a further two or three years, would you?—Yes. What I would suggest is that they should be equalised over those few years.

2799. Equalising must involve a measure of control over assistants' remuneration. You see we took this matter up with the British Medical Association when we saw them and it is apparent that the Association is either unable or unwilling to interfere in the freedom of contract between principal and assistant. Is it your suggestion, Professor Bruce, that more control should be exercised?—I think it can be controlled economically by saying this is the minimum and you will rapidly find people prepared to pay the appropriate rate in order to get assistants.

Sir Hugh Watson: The B.M.A. would not go that length.

2800. *Chairman*: Professor Bruce, I think I am right in saying that the senior house officer can obtain his post after two house officer posts, and this puts him in the same sort of age group as the trainee assistant. There is then the

difference between £850 and £820, so there is not very much there?—No.

2801. The following year he would probably become a registrar—£855 in the first year, £1,062 in the second. Those would largely compare with the assistant of about £1,000 to £1,050. That is less than you thought, is it?—*Professor Dott*: Yes. But a discrepancy does in fact exist which is partly due to the hospital establishments. There are relatively few of these senior house officer posts available so that most of the men who are going on beyond their two first six-month periods have to continue in house officer jobs at the lower rate, not as senior house officers but as house officers for a third and fourth term. That is where the serious discrepancy comes in.

2802. In that case if you were wanting to make the salary attached to a junior house officer post in the third or fourth six-month period comparable with the remuneration of the man who has gone into general practice, you will come up against a difficulty if the house officers are paid partly in cash and partly in kind. This will make the comparison more difficult on the whole?—*Professor Bruce*: Yes, Sir.

2803. Do you think one should be able to make the comparison fairly easily or not?—I do not think it need be in terms of exactness.

2804. But you want the comparison able to be made?—Yes.

2805. *Sir David Hughes Parry*: It has been represented to us that it could be good for the service generally if those who are going into general practice were to spend a year after the pre-registration year in hospital work. Then the parallel would be exact, would it not?—Yes, Sir. It would be excellent if that could be done.

Then this question you have raised would not arise?—That is so.

2807. *Sir Hugh Watson*: It has also been suggested to us that registrars should be allowed to be part-time and should be able, outside their sessions, to act as assistants in general practice or to do research and laboratory work. Would you agree with that suggestion?—I do.

2808. Your suggestion for dealing with the situation to which you refer in paragraph 35 is that there should be a sort

of continuing scale. It would be difficult to work that in the general practice side of the profession, would it not, in view of what we have been just discussing?—Yes, it would be difficult.

2809. In paragraph 44 you deal with a matter which you also deal with in paragraph 90. Paragraph 44 deals with certain of the minor specialties such as ophthalmology and anaesthesia. You say there is now a deficit of doctors undergoing specialist training. If I may take paragraph 90 along with paragraph 44 for a moment, does your view really boil down to this: that the establishment should be increased so as to provide more consultants?—Yes, Sir.

2810. How would you propose that should be done? As we know there are 22 specialties at which consultants could practice. How would this be arranged, *Professor Bruce*?—This would simply mean an increase in the number of consultant posts which were recognised as being recurring and which the service was prepared to pay for.

2811. I think the difficulty the Commission feel about that is that it is not going to be very easy to determine what number of consultants is appropriate for the public service in each speciality. You see what I mean?—That is a matter which of course the profession itself could help in.—*Professor Dott*: A review of consultant establishments has been requested but it has not so far been carried out.

2812. *Chairman*: I think we were told yesterday that the shortage of consultants was at any rate only moderate, that you did not need many more consultants.—We are speaking for consultant surgeons of whom we believe the shortage is more acute. They happened to be a Faculty covering both surgeons and physicians.

2813. Would you feel that the shortage of consultant surgeons makes up more than half the shortage of consultants?—I think a good number of additional consultants are necessary in surgery.

2814. *Sir Hugh Watson*: *Professor Bruce*, this leads us to another point. You consider these increases are necessary from the point of view of the service?—*Professor Bruce*: Yes, from the point of view of the service.

2815. In paragraph 67 you want the proportion of consultant surgical posts

increased in order to provide posts for senior registrars?—That is not why we want it increased. But in point of fact it would create an outlet for senior registrars.

2816. You see you open your paragraph 67 by saying:

"The College has no doubt that the pattern must be altered so as to co-ordinate the proportion of surgical specialist trainees with the anticipated consultant vacancies and with the small amount of 'export' . . ."

—Yes. I feel sure we must relate the number of people to an extended period of very intricate training. We must be able to say to these people: you are almost certain to have a very good chance of obtaining consultant status at the end.

2817. This is a point that causes the Commission considerable difficulty, Professor Bruce. We have been told by many of your professional bodies that there is very keen competition for these posts at the top, to the point that it is practically certain that not all the trainees can ever make the top. Therefore I am not quite clear what your College has in mind about the creation of consultant posts?—The present situation perhaps should be looked at against its background, and its background was the encouragement which was given to a very large number of young men to specialise in the years immediately after the war. So there has been a great glut of well-trained young men who would make admirable consultants but who have not been able to find employment as such. That is rather different from the point we make in paragraph 67. This is long-term. We must be able to relate the number of these people we train in the future to the number of expected consultant vacancies which are likely to come along.

2818. What sort of relationship have you in mind? Would you expect every person who becomes a senior registrar would have the right to expect in due course to become a consultant?—You must still have an element of selection. You must still allow for a little export. It always was difficult to become a consultant. In the case of the Edinburgh Royal Infirmary after a man had completed his fifteen years of office as a consultant surgeon there were three thoroughly trained surgeons only one of

whom could take his place when he was taken off the job. The Colonial Service is nearly dried up now. Also, at one time, a great many were able to buy a practice and do a little surgery in England and combine it with general practice. That has also dried up, so the outlet for those well-trained people has seriously diminished. It is for that reason we suggest this ratio would have to be very carefully looked at.

2819. *Sir David Hughes Parry*: The ratio when determined could be brought about by having more consultants or fewer registrars?—Yes, Sir.

2820. And you suggest the better answer would be additional consultants?—Yes, Sir.

2821. Do you not think it might be a little of both?—Yes, a little of both.

2822. *Chairman*: You would not expect a permanent ratio, would you? These things change. Even in surgery matters change so that demands are not constant, needs are not constant.—I think that is so. It would have to change.

2823. How would it be established. What is the proper establishment? It would have to be decided between the profession and the Government, would it?—Yes, it would have to be agreed between the profession and the Government.

2824. *Professor Jewkes*: May I ask about this slippery word "shortage"? What kind of evidence would you submit to prove that there was a shortage of consultants? If you were trying to persuade other people who did not know about the situation on what would you base your appeal?—We are not saying so much that there is a shortage of consultants but that there should be an increase. The reason why we believe there should be an increase is because we know that work which is properly consultant work is frequently being undertaken by people who are not consultants, by senior registrars. In some cases it is undertaken under supervision; in many cases it is undertaken without supervision. There are a great many people—a great many senior registrars in the country—who are really performing for all practical purposes the duties of a consultant. We think that one of the promises implicit in the Health Service was that for certain types of

work, a consultant would be available for everybody. It is in fact not so. Senior registrars are doing the work.

2825. *Chairman*: Is there a definition of consultant work, Professor Bruce? I have never been quite clear about that.—I do not think I have ever seen one myself, Sir. But a consultant is in effect somebody who is able to take complete charge of a patient at all stages of his treatment.

2826. There are more consultants than there were in the old days?—Yes, Sir.

2827. Quite a lot more?—Yes, Sir.—*Professor Dott*: Could I just add, Sir, to the factors that one would adduce to show there should be an increase in consultants—very simply the one of overwork. Of course, consultants in surgery are severely overworked.

2828. *Sir David Hughes Parry*: You have raised a doubt in my mind whether there are not too many senior registrars, if they are able to do their own work and also consultant work.—*Professor Bruce*: We think there are too many of course.

2829. *Professor Jewkes*: We should have fewer by turning them into consultants?—Yes. They would be doing the same work but it is consultant work all right.

2830. Is there reason to believe that through changes in medical science itself the amount of work consultants have to do is increasing?—Very definitely.

2831. Is there any truth in the statement sometimes made to us that the tendency of the general practitioner is to send more of his cases to the hospitals and that these burden the consultants? Is there anything there?—I do not think so.—*Professor Dott*: It is because more can be done I think. Conditions that were untreatable ten years ago are treatable now because the extent of hospital work has gone up about 30 per cent. in the last ten years.

2832. *Sir Hugh Watson*: Your view is quite clearly there ought to be more consultants. And this is a matter which I suppose each Regional Hospital Board is going, on the advice of the consultants, to take up with the Ministry or the Department?—*Professor Bruce*: Yes.

2833. You deal with the differences, disadvantages and advantages, of part-time and whole-time consultants. I think the Commission has heard a good

deal of evidence about that. We are fairly familiar with the situation. Unless you wish to add anything to what you have said I would not propose to go into it.—I think we have fully stated our views in our written evidence.

2834. *Chairman*: I think you have been a little more firm than anybody else in saying that part-time consultants with only a few sessions should not really be employed at all. Perhaps we will come to that later on. You say appointments involving only a few sessions should be exceptional. It appears in paragraph 55 of your evidence.—Yes, it does. Perhaps it would be convenient to take that now.

2835. *Sir Hugh Watson*: As the Chairman says, you are the only body who have suggested any number of sessions smaller than nine should be agreed only at the specific request of the individual.—Yes, Sir.

2836. Why exactly do you suggest that, Professor Bruce? The average number of sessions we are told—I think that is our information—is six to eight.—Yes, that is so. But we feel that this is one of the ways in which professional prestige and social status can be maintained by having, as it were, a minimum salary for consultant surgeons.

2837. *Chairman*: That also implies, does it, that a consultant working for the National Health Service should always do a minimum of 30 hours a week?—I always understood, Sir, this was not reckoned in terms of hours. These are notional sessions which would cover a man's duties to his hospital rather than be broken down into hours. That is, Sir, how we have looked at it. If Mr. A. is a surgeon to Edinburgh Royal Infirmary, that position and those responsibilities should entitle him to a minimum salary which is compatible with his standing in the community and his education and so on. That is what we had in mind in making this statement.—*Professor Dott*: I think, Sir, on the average we consider that the amount of private practice available as against hospital work is at a lower ratio than of two to nine; and therefore if the average salary does not correspond to nine, then there is hardship.

2838. We gathered the impression that many consultants at present doing far less than nine sessions would feel upset if told they had to get an equivalent of

nine?—Yes, I think that perhaps only applies, or mainly applies, to one place. I only know of one place where there are very small numbers of sessions and that is London.

2839. You say the virtual abolition of less than the maximum, which is nine. We might leave that, but you are in effect the only body that said you thought there should be an abolition of appointments of less than nine sessions.—*Professor Bruce*: We have had in mind in preparing this document that we feel quite strongly there has been a lessening of the prestige of the profession and a deterioration in the social status and social opportunities of the profession. This is one of the ways in which we think the status quo could be restored by a little generosity in those part-time contracts. We do make the point that it is ultimately to be agreed between consultant and authority so that nobody could be forced to take it. By and large it would be the rule and something other than that would be the exception.

2840. *Sir Hugh Watson*: Can we come to the one subject which we have had a good deal of evidence about, that is the question of merit awards? Your College views with favour the system of merit awards and you believe the method of awarding is probably the best method that could be achieved. Is it your understanding there is general approval by consultants and students in Scotland about the way in which the system of merit awards is worked?—I think the majority of people in Scotland are quite satisfied with the way that it works and with the method by which it is done. We all realise it is difficult to find an ideal way of coping with this situation but by and large I think the number of people who disapprove is very small.

2841. Is the method by which these awards are given generally known throughout Scotland?—I think so, yes.

2842. We were told only yesterday by your colleagues from Glasgow that there they have a fairly elaborate system of dealing with this matter, which they think a good deal preferable to that done in the East of Scotland or in other parts?—I would not accept that. I think the way it is done in the East of Scotland may be different but it is equally effective.

2843. All we are concerned to find out I think is whether so far as your knowledge goes, the profession is satisfied?—The large majority of the consultant profession is satisfied so far as my knowledge goes.

2844. Could I put it to you this way? Is the profession satisfied that every person who has a claim to a merit award or who conceives he has a claim to a merit award, has his claim considered?—That is absolutely so. I have no doubt about it.

2845. Have you any views about the question of secrecy of these awards, *Professor Bruce*?—Secrecy is always unfortunate but I cannot conceive of this being done in any other way than in secret. Any other way would have the gravest possible objections.

2846. Both from the point of view of the person who had the award and from the person who had not?—Both.

2847. Have you any views as to the question of whether the award should follow the person or take the nature of a responsibility payment and go with the post?—I believe it should be associated with the person and not with the post. There is just one point which we have not made before but which you may like me to make now. It is less certain that the relative proportions on a national basis as between Scotland and England are what I would have made them at the time.

2848. There are about 1,000 consultants in Scotland. Am I right?—800 I am told.

2849. And 6,700 in England?—It so happens a very large number of consultants in Scotland are associated with teaching hospitals and while I do not say that in itself should make the man eligible for a merit award it is a very important job. They put in a lot of extra work in relation to teaching in the University which is not very well rewarded. I think by and large those people accept willingly this load of teaching and should have special consideration. At least it should be an important factor amongst others in deciding whether they are worthy of a merit award or not. Scotland has a very high proportion of these and Scotland also produces about one-quarter of all the doctors in this country, so it is a very important Scottish contribution. I have had the

feeling, without wanting to specify it in numbers, that a slightly larger proportion of merit awards would be appropriate in Scotland.

2850. *Chairman*: Is that at all levels—the C, B and A merit awards, or particularly at the top where this teaching is so important?—I think it is at all levels, Sir.

2851. *Sir Hugh Watson*: But apart from that you are quite satisfied with the merit award system?—Yes, Sir, but could I make one more point? I and my colleagues have the feeling that there might be even further merit awards; that there should be a small proportion, perhaps one or 1.5 per cent. of really outstanding merit awards, so that it would be possible for somebody in medicine who was completely outstanding to be rewarded on the sort of scale which obtains in industry and in the law and elsewhere.

2852. Some glittering peaks. You mention them, but you have a pretty high level plateau already, to use your own expression, Professor Bruce. Would you call this 1.5 per cent. an insignificant minority perhaps?—Yes.

2853. Spens you see advocated the glittering peaks for a significant minority. You remember the words very well, I am sure?—Yes, it would correspond I should have thought to the number of Senators of the College of Justice.—*Professor Dott*: 1 per cent. would be about 70 over the whole country.

2854. *Chairman*: Are you really implying that merit awards are going to a third of what is now a very much larger number of consultants than existed at the time the Spens recommendations were made; that the merit award is no longer just an indication of extreme distinction because they are now so many? You want something at the top to make a further distinction. Do you want these glittering peaks to be visible to all or to be a secret?—*Professor Bruce*: Secret.

2855. *Professor Jewkes*: So high they will always be in the clouds. Is that the suggestion?—Yes.

2856. *Sir Hugh Watson*: One of the troubles about that would be that a very high proportion of such remuneration would go in taxation, would it not?—Yes, it would. It would not make very

much difference to a man's income. It would make some difference to the pension. It would make a tremendous difference to his morale and cost the country very little.

2857. The country would get it all back in taxes, Professor.

On the question of retirement, in paragraph 100 you make a suggestion not made to us before with regard to superannuation and it is an interesting suggestion. Has this suggestion been made to the Government Departments?—No, Sir, not as far as I know.

2858. I think it might well be taken up with them.

I think in the perhaps curious way in which we have done it we have pretty well gone over the ground covered by your memorandum. You summarise it in the last page in eight suggestions. Unless you want to direct our attention to any one of these eight points which you mention there I do not think I have any further questions to ask you.—No, Sir.

2859. *Chairman*: I would like to ask you one or two questions, Professor Bruce. The other Scottish bodies have suggested there are many advantages in having an intermediate grade between senior registrar and full consultant. What do you think about that?—We are against it absolutely.

2860. You know that Glasgow on the whole are for it?—Yes, Sir.

2861. Is that due to the different system in the west of Scotland—the hierarchy among consultants within the hospital?—We have the same system but we regard consultant work as indivisible.

2862. On the other hand you were rather inclined to think that surgeons have particular difficulties. Do you regard consultants indivisible in every dimension?—I do not quite follow, Sir.

2863. You were rather, I think, anxious that surgeons should be specially considered in some of these matters?—Not surgeons necessarily but those parts of the profession having a considerable physical strain, including general practitioners if you like, and certainly obstetricians and gynaecologists—those whose work does involve a very

considerable physical effort and often prolonged physical effort.

2864. But you do regard all consultants as equal whether they are radiologists or surgeons?—Yes.

2865. The other point I wanted to take up quite briefly, which we have not really touched on apart from entry, is general practice. Have you any particular views or suggestions you wish to make on remuneration in general practice?—No, Sir.

2866. You leave that subject to others?—I would like to refer for one moment to this question of the specialist as opposed to the consultant. It seems to me this is an attempt to absorb senior registrars who are really fit for consultant status; there is a great reluctance to admit they are in fact consultants. I think that we might just instance the case of the three people before you this morning. Professor Dott was a consultant at the age of 24 and a senior consultant at the age of 28. I was appointed to the Royal Infirmary as consultant, seven years after qualifying, at 30 years of age. Mr. Mason Brown was elected a consultant at hospital at the age of 28. So it is not unusual that these young men should be regarded as consultants. We won our spurs by election to hospitals. We were not the best consultants then; when you begin you are not a consultant who is con-

sulted on the most difficult cases. But the State does recognise grades of consultants because you start at the lowest rung of the ladder. There are eight salaried grades and plenty of steps on the ladder to consultant establishment without putting an extra one in and calling him a specialist. I would really feel—and my colleagues also feel—strongly against the introduction of a grade like a specialist grade.

2867. *Sir David Hughes Parry*: You did indicate there would be some senior registrars who really would not gain the rank of consultant?—Who would not make the grade.—*Professor Dott*: We felt they would not stay as senior registrars but would take up something better suited to their capacity.

2868. *Chairman*: In the nature of the work there would be room for this intermediate grade?—*Professor Bruce*: In certain specialties as, for example, ophthalmology and the school eye testing service. There are certain jobs which are not full consultant jobs, but they do not exist in surgery.

2869. You are confining yourself really to surgery in your views?—Yes, Sir.

2870. I think that is all. We shall be seeing the Royal College of Physicians this afternoon.—Thank you very much for the opportunity of putting this evidence before you.

(The witnesses withdrew.)

ROYAL COLLEGE OF PHYSICIANS EDINBURGH

Memorandum of Evidence to be submitted to the Royal Commission on Remuneration of Doctors and Dentists

INTRODUCTION

1. It was in 1681 that a Charter was granted to this College by King Charles II. The Royal College of Physicians of Edinburgh was founded as a Society and College consisting of "grave, learned and upright persons" as an "appropriate and effectual means and remedy" to reform certain abuses in medical practice and to "prevent their recurrence for the future."

2. During nearly three centuries of changing patterns of medical practice, the College has, whenever events have suggested such action to be appropriate, put forward to the relevant authorities the considered views of its Fellows about reforms in medical practice or education. The College welcomes the opportunity of so doing once again.

3. The Laws of the College provide for the election annually from amongst the Fellows of a President and a Council of six, one of whom is Vice-President. There are quarterly meetings of the Fellows and monthly meetings of the Council, but

meetings may be called at any time. Lectures are given at the College, hursaries are administered, and various committees are set up from time to time. There is a fine library widely used.

4. The College represents 404 Fellows scattered throughout the world, although mainly resident in Great Britain, together with a large number of Members who are admitted only after a high standard of examination. At the present time there are some 1,400 of these Members, the great majority of whom hold responsible positions in hospital practice. From these, in due course and according to merit and achievement, the Fellows are chosen.

5. In this connection it is pertinent to mention that Membership or Fellowship of one or other of the Royal Corporations is virtually an essential qualification for all applicants seeking consultant posts on the medical side of hospitals. Furthermore, it should be pointed out that, according to our practice, it is unusual for a Member to be advanced to Fellowship until he has achieved consultant status. Thus it follows that the men who speak for our College are only those who themselves have graduated through a long and arduous training, and are therefore aware of the many pitfalls in the ladder of promotion. The College speaks not only for consultants but for all grades of medical staff in the hospital service, and welcomes the opportunity of submitting evidence to the Royal Commission on the Remuneration of Doctors and Dentists.

6. A Committee, consisting of the following Fellows, was appointed to prepare the evidence for submission to the Royal Commission.

Sir Stanley Davidson, President (*ex-officio*); Dr. W. I. Card; Dr. J. Halliday Croom; Dr. A. Rae Gilchrist; Dr. R. H. Girdwood; Dr. I. W. B. Grant; Dr. J. K. Slater; Dr. J. H. Wright.

7. The Convener of the Committee was Dr. J. K. Slater and the Secretary was Dr. R. H. Girdwood. The composition of the Committee in regard to contracts with the National Health Service was as follows:

Sir Stanley Davidson; Dr. Card; Dr. Girdwood. Full-time members of the staff of the University of Edinburgh and Honorary Consulting Physicians in the N.H.S.

Dr. Halliday Croom; Dr. Gilchrist; Dr. Slater; Dr. Wright. Part-time Consulting Physicians in the N.H.S.

Dr. Grant. Full-time Consulting Physician in the N.H.S.

8. The profession of Medicine has always been an honourable and respected one and must remain so. To such a career there must be attracted men of intelligence, of integrity and of character. Remuneration must not be the main pre-occupation of the medical graduate or of the bodies that represent him, but the doctor should not have to worry constantly about financial difficulties. He must remain an individual with a personal relationship to the patient rather than become a civil servant. At the same time Medicine must continue to advance as a science. The Harveys, the Jenners and the Listers of the future must not turn to other fields because of poor prospects or facilities in a nationalised medical service.

9. Few could have foreseen the disputes that have arisen over remuneration and terms of service between the Profession and the Government in the past ten years. Most of these disputes have been a consequence of the unexpectedly rapid decline in the value of money. The fall which has taken place in the standard of living of the professional classes, including doctors, is closely related to the social revolution which has occurred with the development of the Welfare State. The income of the working classes has more than kept pace with inflation but that of the professional, middle and upper classes has not. Although initially this change was in the right direction we believe that it has gone too far. Unless the financial reward of the professional classes is commensurate with their long training, their intellectual talents and the important service they render to the community, the recruitment of adequate numbers of the right type of person to the professions will become increasingly difficult.

10. The Spens recommendations were intended to ensure that the doctor, whether general practitioner or consultant, would continue to have a standard of living that would give adequate compensation for his arduous years of study, his long hours of work and his great responsibilities. It was because the Government of 1948 accepted the reports of the Spens Committees (Medical) that the doctors agreed, with reluctance, to enter a nationalised service. Between 1951 and 1956 the value of money fell by 24 per cent but the various branches of the medical profession received only minor increases in emoluments which in no way corresponded to the increase in the cost of living. The Committee realise only too well that so long as taxation remains at its present high level and inflation continues, it would be impossible for the Government to implement the Spens Committees' recommendation that the standard of living enjoyed by the Profession in 1939 should be maintained. It is for this reason that the Committee urges the Government to take the most vigorous steps to reduce taxation and counter inflation. Until this is accomplished, however, the Profession has no alternative but to ask the Government to grant such increases in remuneration as are just and practicable.

THE PRESENT SITUATION

The Choice of Medicine as a Career

11. Medicine is a satisfying career for a young man with a sense of vocation. He will remain well content with his work unless, later, he is turned from his true purpose in life by pre-occupation about the uncertainties of his future, by financial difficulties, by problems created by bureaucratic administration, or, from within, by a change of heart.

12. It would be naïve to suggest, however, that all or even the majority of medical students have taken up this career because they feel that they have been called to do so by Providence. Many factors are involved in the selection of a career, such as family traditions, the influence of friends and relatives, and suggestions by parents, headmasters and teachers.

13. Most schoolchildren and even many undergraduates have little immediate interest in the financial aspects of their future career, but their parents are likely to regard this as an important consideration. It is not uncommon now for parents, including those with medical qualifications, to be reluctant to encourage their children to choose a career in Medicine because of current uncertainties in professional prospects and the impression that there has been a lowering of the social and economic standing of the doctor in the community. On the other hand it must be said that many parents have no such misgivings while others believe that by the time their children have qualified as doctors the present difficulties will largely have been resolved.

The Medical Undergraduate

14. The Carnegie Trust and the Scottish University bursary scheme have always made it possible for the Scottish boy of humble origin to become a medical student. The opportunities have been greatly extended by the post-war Local Authority grants, although the Scottish student does not fare as well as his English colleague because of the smaller grant that he receives. To assess the need for a grant and to determine its amount on the basis of the gross income of the parent as is done at present may lead to injustice. Thus parents who at first sight appear to be well off, but who in fact have heavy expenses, cannot afford to send their sons and daughters to a medical school as they will receive no grant. Hence a professional man, such as a doctor, may be unable to pay for the education of his sons or daughters at a university whilst his working-class patient may be able to obtain the means to do so.

The Newly Qualified Medical Graduate

15. The newly qualified doctor has no difficulty in obtaining an appointment as a house officer, although naturally all cannot be accommodated in teaching hospitals. The man who spends his first postgraduate year in non-teaching hospitals is at a considerable disadvantage if he aspires to a career as a consultant but the outstanding graduate is unlikely to have difficulty in obtaining the type of junior

post in hospital he wants. The house officer has little cause for complaint about his salary or his security. There can be no doubt, even in his own mind, that he is a trainee and that he is much better off financially than was the house officer before the National Health Service was introduced. It is at this stage, however, that he begins to learn from the discussions going on around him that his future may not be quite as promising as he hoped. Already he is likely to be meeting senior registrars who have been unable to obtain consultant posts, even though they may be men of great ability.

The General Practitioner

16. The aspirant to general practice can apply for an appointment as a trainee assistant, but the applicants are numerous and the vacancies few. The chief problem in general practice, however, is how to become a principal. The number of applicants for an attractive vacancy is always large; the hazards involved in building up a new single-handed practice even in under-doctored areas are great; it is, of course, impossible for an assistant in general practice to become a partner without the agreement and active support of the practitioner he has been assisting.

17. In the report of the Scottish Medical Practices Committee issued in September 1956 there were 2,551 general practitioners listed as practising in Scotland as principals and 40 with limited lists. They employed 253 assistants and had, in addition 87 trainee assistants. The total number of 340 existing assistantships in Scotland is so small in relation to the annual number of Scottish medical graduates (486 in 1956) that a large proportion of these graduates must seek employment in other spheres or even in other countries.

18. The path to successful general practice was never easy even before the National Health Service, but now restrictions, sensible though they may be, are many and there is little scope for private practice. Even when the graduate does become established as a principal in general practice he is not necessarily assured of an adequate income. According to figures prepared by the British Medical Association, the average gross annual income of a general practitioner in 1956 was approximately £3,000, yielding after deduction of practice expenses an average annual net income of £2,222. In Edinburgh, however, of the 258 general practitioners on the list of the N.H.S. Executive Council 65 (25 per cent) had an annual income from the Service of £1,000 (gross) or less. Thirty-three of these doctors were classified as junior partners. A gross income of between £1,000 and £2,000 per annum was earned by 39 doctors (14 per cent). The remaining 60 per cent had an annual income which varied between £2,000 and £5,000 (gross). It would appear that many doctors regard the education and social advantages which residence in Edinburgh affords, as sufficient recompense for an income much below the national average.

The Registrar Grade

19. One of the intentions of the Spens Committee was to make the early years easier for the potential consultant. There is no doubt that, in the past, the graduate without private means was apt to have a hard time in his earlier years, whether his goal was specialist or family practice. If, however, he failed to achieve consultant status he could turn readily to general practice, profiting by his experiences and by his contact with teaching hospitals, all the wiser from having worked for and obtained a higher qualification. Now the lines are more rigid. In general the registrar is considered to have made his decision to be a specialist and the assistant in general practice to be a family doctor. To advance along the normal channels is difficult enough. To attempt to change direction in midstream is even less easy. We would like to see it made easier for registrars to be part-time in general practice while working in hospital, so that at this stage they could still choose between family and hospital practice. This could only be beneficial to the standard of work in the National Health Service.

20. A major problem is that of the unfortunate "time expired" senior registrars, many of whom are doing consultant duties as they await the retiral, death or translation to other spheres of their senior colleagues. The consultant occupies his post for some thirty years; the original intention was that the senior registrar would occupy his post for four years. It is not surprising that such a mathematically

impossible scheme has broken down, and we suggest that the senior registrar post should become a permanent one with a higher maximum salary and a new title of Senior Assistant Physician/Surgeon. We suggest further that in general medicine, surgery and obstetrics these posts should be limited to teaching hospitals, and that in the more restricted specialties, such as tuberculosis, they should replace the S.H.M.O. posts. The post of Senior Assistant Physician/Surgeon should be the normal stepping-stone to consultant status.

The Consultant

21. The consultant is a man of experience. He has climbed up the various steps on the ladder of promotion in the hospital service and now holds a most responsible post. In diagnosis and treatment the final responsibility is his. He may be supervising or carrying out the research projects that daily advance our knowledge; he may be a clinical teacher, instructing and inspiring undergraduates and post-graduates; in modern times he almost certainly will serve on many committees. A person doing such important work should not be hampered by continual financial cares and pre-occupations. Unfortunately this is too often the case and the Committee believes there is ample evidence to show that many consultants are acutely anxious about the present situation and about the future.

THE FUTURE

22. The Committee considers it essential that the machinery for adjusting remuneration and terms of service should be drastically overhauled. If disputes over remuneration and security can be resolved smoothly and equitably this will go far towards eliminating the controversies which have so unsettled relations between the medical profession and the State in recent years.

23. The Priestly Commission recommended the establishment of a small permanent committee to keep under review the salaries of the higher civil servants, and to advise on revision of these salaries periodically in accordance with changing conditions. This Committee of the Royal College of Physicians of Edinburgh considers that a neutral body of this nature would serve the interests of the medical profession, the Government and the public.

24. Finally the Committee wish the Royal Commission all success in recommending to the Government such measures as will safeguard the standard of living as well as the status and independence of the medical profession.

THE ROYAL COMMISSION ON REMUNERATION OF DOCTORS AND DENTISTS REQUESTED THE COLLEGE TO GIVE ITS VIEWS ON 21 TOPICS. THE COMMITTEE FELT COMPETENT TO PROVIDE INFORMATION ON 15 OF THESE POINTS.

(i) The quality and quantity of recruits (a) offering themselves and (b) accepted for training as medical students.

25. It has been considered in recent years that the British medical schools have been producing too many doctors for the available posts. Indeed the Dean of Postgraduate Medical Studies at Manchester University is quoted (*B.M.J.* 1955, 1, Supplement, p. 5) as saying in 1954 that if the medical schools in this country continued to have as large an intake as they had then the cumulative excess of doctors might, by 1959, amount to 5,000 or 6,000.

26. In 1955 the Government set up the Willink Committee "to estimate on a long-term basis and with due regard to all relevant considerations, the number of medical practitioners likely to be engaged in all branches of the profession in the future, and the consequential intake of medical students required."

27. To meet the changing circumstances the Scottish medical schools have in recent years endeavoured to admit a smaller number of medical students than previously. Moreover there are no longer classes for the Triple Qualification in Scotland, and although examinations for this qualification are still being held, the entry is very small, consisting chiefly of overseas students.

28. To exemplify the trend we show in Table I the number of applications and acceptances for undergraduate vacancies in Medicine at Edinburgh University during the past nineteen years.

TABLE I

The selection of medical students by Edinburgh University

	Applied	Accepted
1938-9	521	212
1939-40	505	214
1940-1	487	206
1941-2	480	209
1942-3	492	196
1943-4	501	200
1944-5	635	197
1945-6	823	217
1946-7	1,425	207
1947-8	1,680	202
1948-9	1,466	198
1949-50	1,484	192
1950-1	1,622	190
1951-2	1,279	188
1952-3	826	176
1953-4	841	178
1954-5	849	180
1955-6	789	178
1956-7	769	146

29. Table I also shows that in recent years the demand for places at the Edinburgh Medical School has appreciably slackened. Although the number of applications still greatly exceeds the number of vacancies the surplus is much smaller than in the immediate post-war years. Conditions at that time were, however, exceptional and the figures cannot be regarded as an accurate index of the popularity of Medicine as a career. Nevertheless, provisional figures for 1957-58 (not included in Table I), based on the grading of entrants according to examination results, age, and headmasters' confidential reports, show that, so far as *men* educated in Britain are concerned, the point has now been reached where the great majority of suitable candidates are admitted. The real reserve, therefore, of people who cannot be accepted because of the limitation on the number of entrants, but who are suitable on grounds of ability to study Medicine, exists only among (a) women applicants, British as well as Commonwealth and foreign, and (b) Commonwealth and foreign men. We understand that a similar situation exists in the other Scottish medical schools.

30. There are several possible reasons why the number of suitable British male applicants for medical training is falling but the fact that such a trend exists suggests that a medical career is not considered as attractive as it used to be for British men of high scholastic attainment. It seems that many such men who in the past would have applied for entry to a medical school are now seeking other careers. We have no factual information on which to base an explanation of this change of attitude but the following are a few of the considerations which may apply:—

- (1) Some potential applicants to Scottish medical schools may have been deterred by the increase in the period of training from five to six years.
- (2) Some applicants, particularly from England, prefer to go to English medical schools which permit the first-year examinations to be taken from school, thus in effect reducing the course to one of five years.
- (3) The propaganda "build up" now being given to science and technology may have diverted to those spheres many men who might in the past have

favoured Medicine. It is possible to come to a position of responsibility more rapidly in science than in medicine.

- (4) The publicity currently being given to pay and prospects in the National Health Service may, rightly or wrongly, have adversely influenced potential applicants to medical schools or their parents.
- (5) There may be a genuine belief among such people that Medicine as a career is now, relative to certain other occupations, less remunerative, less secure and more bureaucratic than it was before the inception of the National Health Service.

31. Regarding the quality of applicants for medical training, no valid comparison can be made of the applicants as a whole with their predecessors of, say, ten years ago. The educational and other standards governing selection have certainly not been lowered; indeed they have probably been raised. In 1956, all recruits accepted for training fulfilled these standards and it is thus most unlikely that they were of poorer quality than in previous years. If, however, the present trend continues it will not be long before there are too few suitable applicants to fill the number of places at present made available. The deficit will first be of British men and, if it is decided to maintain the present number of places, either the standards of entry for British men will have to be relaxed or the vacancies filled by British women or by Commonwealth and foreign students. On the other hand it may be considered desirable to reduce the intake of medical students still further, and for guidance on this matter we await the findings of the Willink Committee.

(ii) **The quantity and quality of newly qualified doctors.**

32. For generations the Scottish medical schools have sent doctors to towns and villages throughout the country, to hospital posts, to appointments throughout the Commonwealth and in the Services, and to high office in other medical centres. Though this tradition continues, it is clear that the export market is contracting.

33. The following figures give the number of medical students graduating in various years from the three countries.*

Year	England	Scotland	Ireland	Total	Scottish Graduates as percentage of total
1934	847	471	154	1,472	32
1937	1,096	593	239	1,928	31
1940	1,323	673	315	2,311	29
1945	1,268	581	428	2,277	26
1949	1,436	589	452	2,477	24
1952	1,848	673	506	3,027	22

34. They show that, in the post-war years, there was a great increase in the number of medical graduates from the English and Irish schools, while the Scottish schools showed no such proclivity.

35. In view of the diminishing opportunities for practising in the Commonwealth and because of the increased number of doctors graduating in England and Ireland the Scottish graduate is finding it more difficult to obtain a permanent post either in the National Health Service or outside it.

36. So far as the quality of the newly qualified doctors is concerned, the Committee has the impression that the present medical graduate compares favourably with his pre-war counterpart, though it cannot support this opinion with any objective evidence. Indeed, because of the compulsory pre-registration year that must be spent in hospital work, the quality of the average man going into practice is probably higher than it was in the years prior to the war.

* Sir Stanley Davidson, B.M.J. (1955), 1, 1171.

(iii) **Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation**

Wastage during training

37. In May, 1957, the Faculty of Medicine of Edinburgh University investigated the problem of wastage among medical students who entered the medical course in the four years between 1948 and 1951. Wastage here means the number who have departed without qualification.

38. The following were amongst the conclusions reached:

- (a) Between a fifth and a quarter of entrants to medical studies in Edinburgh University failed to complete the course. The great bulk of this wastage was the result of failure in the First and Second Professional Examinations.

The amount of wastage among men and women was about the same, but examination failure was less prominent as a reason for wastage among women.

- (b) Comparison of performance at First and Second Professionals with eventual achievement showed that these examinations are good indications of the students' ability to succeed in the course as a whole.

- (c) Other factors affecting wastage, such as the age at entry of students to the University, the nationality of students, the type of school from which the students come, previous educational qualifications, etc., are at present being investigated, but sufficient data has not been accumulated to enable final conclusions to be reached.

Wastage in the first few years after qualification

39. It is often stated that many recently qualified doctors are emigrating because of the difficulty of obtaining permanent posts in this country. The evidence for this is conflicting. A senior Fellow of our College has informed us that of his last 32 house physicians, a number that includes 5 women, there are now 6 men working abroad and, perhaps even more important, these were all decidedly bright and ambitious young men. On the other hand, of 149 medical students who graduated in Edinburgh in 1946 (see Table, p. 17) only 16 of British origin have left this country during the past 10 years, while 8 out of 9 overseas students are working in the United Kingdom.

40. It is widely believed that Canada is the country which offers the best opportunities for doctors who wish to emigrate. It is plain, however, from the information in an article by Mair & Hatcher, published in the *British Medical Journal* of 7th September, 1957, p. 539, that the opportunities for such immigrants must be limited because the ratio of doctors to persons is actually higher in Canada (1 to 948) than in England and Wales (1 to 980). This article also shows that the total number of doctors emigrating to Canada from all countries in the world was only 708 for the three-year period 1951-54. It may be concluded, therefore, that emigration is not an important cause of wastage in the first few years after qualification.

41. Marriage of female medical graduates is another factor which must be considered in regard to the problem of wastage; in Edinburgh some 25 per cent of medical graduates are women. The Committee unfortunately has no factual data to submit to the Commission in this connection.

(iv) **The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them)**

42. *Duration*: The medical course is one of six years' duration. In some of the English universities it is possible to take the first-year examinations from school, without attending the university classes, or even, in some instances, to be exempted from the examinations. At present there is a Scottish University Ordinance under consideration by the Privy Council and Edinburgh University intends to allow suitably qualified applicants in October, 1958, and thereafter to sit the first-year examinations without attending university classes directed towards these examinations.

43. On the one hand this cuts the university course for these students to five years; on the other hand there is the serious drawback that it leads them to specialise at an early age and must narrow their breadth of general education.

44. *Cost*: At Edinburgh University the cost of fees and books is approximately £550 for the six-year course. To this must be added, in many cases, the cost of subsistence. This is at least £4 10s. per week or nearly £1,400 for the six years. In addition the lack of earning power in these six years requires consideration. Against this must be offset the following:

- (1) Local Authority grants.
- (2) Bursaries obtained in the Scottish University Bursary Competition.
- (3) Carnegie Grants.
- (4) Paid employment in vacations.

45. For some time the Scottish student has had a sense of grievance because the English student, even if attending a Scottish university, is likely to have a better local authority grant. The maximum annual amount which a medical student can receive from Edinburgh Education Committee is at present £231. An English student at Edinburgh University can receive under the English regulations at least £30 more per annum. This means that against the estimated £1,954 expenditure for six years referred to above, the English student receiving a full grant would be given at least £1,566, whilst the Scottish student would be given £1,386. On the other hand the Scottish student in poor financial circumstances may have his university fees paid in whole or in part by the Carnegie Trust, even if he is in receipt of a maximum local authority grant. If he obtains a bursary in open competition no deduction is made from his local authority grant unless the value of the bursary exceeds £60.

46. In Scotland there is a higher proportion of students per head of the population than in England, and this is at least partially responsible for the lower awards that are made to Scottish students. This differentiation is unfortunate, but we do not feel that real hardship is experienced by medical students or that financial difficulties prevent any really suitable student from becoming a doctor.

47. We understand that some English students have stated that their local education committee has refused to give them grants to study in Scottish universities with a six-year medical course because they were qualified to sit the first-year examinations from school at certain English universities. We have no documentary evidence to support this statement.

48. A problem worth recording is that the decision as to whether or not a student receives an education authority grant depends in part upon the parents' income. Apart from allowances for dependent children, superannuation, life insurance, feu-duty and interest on a bond on the house, it is the *gross* income that is taken into account, and this may operate most unfairly on parents with necessarily heavy expenses (e.g. a general practitioner with heavy practice expenses).

(v) Position and prospects of a newly qualified doctor

49. It is not possible to generalise about the position and prospects of a newly qualified doctor. In one sense the situation is similar for each new graduate—he has a feeling of achievement after a long, exacting and arduous course of study; the prospects for his future depend on many factors including the branch of Medicine that particularly interests him, the influence of medically qualified relatives and family traditions, whether or not he is married, and above all, his natural ability and capacity for hard work. If however a student does reasonably well in his undergraduate course, he has a much better chance of obtaining posts that will ensure that he is well trained in the years immediately after qualification. *Ipso facto*, a man who is well trained has a better chance of succeeding in his subsequent career.

50. For most medical graduates there is likely to be available immediately after qualification some post or other in this country, and it is not until a few years later that some graduates, no matter how brilliant they may be, feel themselves

thwarted in the search for permanent posts in the branch of Medicine that they have chosen to follow. Parents, teachers and older schoolchildren are becoming increasingly aware of the difficulties that may face the medical graduate in his search for a permanent position.

51. Medicine is a dynamic subject that must not be allowed to become stagnant from lack of first-class graduates. It must continue to attract recruits of the highest calibre. We fear a deterioration in the quality of those seeking a career in the medical profession, and already feel that Medicine is losing its attraction, faced as it is with an ever growing competition from the numerous alternative prospects that have become available to the keenest schoolboy brains.

52. The reasons for this are not essentially financial—indeed we would not wish money to be the chief goal of the schoolboy looking to Medicine as his possible life work. The factors are many and complex, but they include:

1. Competition from Science and Business as possible careers for those with brains and character.
2. The politically involved state of Medicine at the present time and consequent uncertainty about the future.

53. Taking a typical year of a decade ago, thus allowing sufficient time for graduates to choose their pathway or follow the vagaries of chance, the information given in Table II indicates the present status of 149 graduates qualifying in Edinburgh in the year 1946.

TABLE II

The Status in 1957 of 149 Medical Graduates who qualified in Edinburgh in 1946

Status in 1957	At present in the U.K.		At present outside U.K.	
	No.	percentage	No.	percentage
A. General Practitioners	63	42.3	5	3.4
B. Consultants	5	3.4	1	0.7
C. University Staff	4	2.7	5	3.4
D. Hospital Medical Officers	38	25.5	3	2.0
E. Medical Officers of Health	6	4.0	2	1.3
F. Services	4	2.7		
G. Not in Register	5	3.4		
H. Occupation not known	7	4.7	1	0.7
	132		17	

Of the 149 students who graduated, 9 are listed as coming from overseas (8 Commonwealth and 1 Czechoslovakia).

Of these 9, 8 are at present working in the United Kingdom; 1 has returned to his native country (Malaya).

Of the 17 graduates at present employed outside the United Kingdom, 16 are from the United Kingdom; 1 has returned to his native country (Malaya).

It is of interest to note that of these 149 graduates, 63 subsequently obtained additional qualifications, and that these 63 graduates hold 85 additional qualifications between them.

(vi) **Any trend to excessive resort to certain branches of the profession at the cost of others**

54. The law of supply and demand obviously operates in this matter, but clearly in hospital practice the majority of ambitious young men desire to pursue one or other of the principal medical or surgical specialities unless, as sometimes happens, a graduate has a special flair, or perhaps a family interest, in one of the less popular subjects. In the main no evidence of any such tendency as this question suggests is seen, but it should be observed that there is an insufficient desire among well-trained men to enter in the first instance the specialities of Radiology, Dermatology and Psychiatry, among others.

- (vii) The relative advantages and disadvantages, financial and otherwise, of service as (c) a whole-time consultant in the National Health Service

55. It should be stated that the type and extent of the work performed by the full-time consultant varies a great deal according to the nature of his speciality (e.g. General Medicine, Tuberculosis, Geriatrics, etc.), whether he is working in the city or in the country (e.g. in a sanatorium or mental hospital) and whether he is employed in a teaching or a non-teaching hospital.

Advantages:

56. (1) Security.
(2) A reasonable income.
(3) The present generation of whole-time consultants tend to be relatively young on appointment to these posts and thence they can look forward to a satisfactory pension on attaining the age-limit.
(4) (a) The whole-time consultant in a university or teaching centre, freed to some extent from the distractions of private consulting work, has often a greater opportunity to develop a special line of interest, or to devote himself to some particular aspect of clinical investigation of his own choice, perhaps including laboratory research. He has therefore often a greater opportunity for original work.
(b) The whole-time consultant in a non-teaching hospital may not have these opportunities.
(5) Medicine is more than ever dominated by committees. The whole-time consultant can give valuable service in this respect, often without the personal sacrifice demanded of his part-time colleague.

Disadvantages:

57. (1) Income tax. He is on Schedule E and hence has no allowance for car, medical journals, membership of learned societies, etc. (see p. 30). This is a grave disadvantage, as unreasonable as it is unjust. He has no car allowance from the Regional Hospital Board for travel from his home to his hospital, but in most instances needs to have his car with him at home or at his parent hospital for calls to patients at their homes or in other hospitals.
(2) In certain areas he is greatly overworked and may have to visit outlying hospitals, scattered over a large area. In some localities the arrangements for deputies are inadequate.
(d) *A part-time consultant with the maximum number of sessions*

Advantages:

58. (1) Professionally he has the great advantage of contact with the community as a whole and therefore brings to his work a wide experience culled from both his hospital and private patients, as a result of which both stand to benefit.
(2) Financially he can supplement his salary by other activities—e.g. private practice, domiciliary consultations, life insurance work, and service on statutory boards and medical appeal tribunals. If he has already the maximum number of sessions there will, however, be little time left for activities such as these.
(3) His professional expenses are often heavy, but he has a measure of income tax relief, which eases the burden.

The Committee believes that it is all to the good of the community and to the profession that there should be a place for the part-time consultant.

Disadvantages:

59. (1) Private consulting practice is declining. Formerly, much of a medical consultant's income was derived from long-distance visits to the patient's home. This type of work is now reduced to negligible proportions, as local consultants are generally available in most areas of Scotland and more often than not, the patient in need of a specialised opinion requires the full diagnostic resources of the hospitals.

60. In the earlier years of private consulting practice, the consultant's professional expenses are necessarily heavy. In the past the lean years were compensated by the expectation of a good income later. In many areas of Great Britain to-day junior part-time consultants do not feel justified in committing themselves to the heavy burden of maintaining private consulting-rooms with secretarial assistance and other expenses, in the face of a declining source of income. For economic reasons the great majority of "second opinions" are obtained at the hospital and not in private practice.

(e) *A part-time consultant with only a few sessions*

61. We understand that in London and possibly in certain other medical centres some physicians on the staff of teaching hospitals are paid for only three or four sessions per week, as presumably this is considered to be adequate for the purpose of carrying out their duties satisfactorily. Such physicians are, we believe, men who enjoy a large consultant practice established in many cases prior to the inception of the National Health Service, and who for this reason do not desire further sessions. In most areas, however, the amount of private practice is strictly limited and mainly undertaken by established senior consultants. Accordingly the opportunities for private practice for a newly appointed consultant are negligible, the income from three or four sessions is totally inadequate, and the prospects of a satisfactory pension are poor. For the above reasons we consider that appointments involving less than six sessions should be made only in exceptional circumstances.

(f) *A Senior Hospital Medical Officer*

62. The Hospital Medical Officer appointments, Senior and Junior, were introduced at the inception of the National Health Service as an interim measure to deal with transferred Local Authority Medical Officers. Neither the Government nor the profession intended this type of appointment to be a permanent feature of the new service and there was a tacit agreement that such appointments would not be made in the major specialties. With certain exceptions, notably in the Western Region of Scotland, this agreement has been kept and the main field for the employment of S.H.M.O.'s has been such specialties as Anaesthesia, Geriatrics, Ophthalmology, Pathology, Psychiatry, Radiology and Tuberculosis. Although in a few teaching units in these specialties the post is regarded as a rung in the promotion ladder to consultant status, in the vast majority of cases it is a post without real prospects of advancement. Even in those few instances in which it is regarded as a "pre-consultant" post, the prospects of promotion are largely illusory as consultant vacancies so seldom occur.

63. It is against this background that the advantages and disadvantages of the S.H.M.O. appointment must be viewed.

Advantages :

64. The post is permanent, i.e. it carries security of tenure with all that implies. It confers financial stability and brings release from the constant competition for senior registrar appointments.

65. The post is reasonably well paid as compared with that of a registrar or senior registrar, the salary ranging from £1,653 to £2,126 per annum.

Disadvantages :

66. (1) The post of Senior Hospital Medical Officer seems to engender a sense of frustration amongst all those who hold it, unless they are devoid of professional ambition. In teaching hospitals their feelings of frustration are based less on financial considerations than on the prospect that they may be denied full clinical responsibility perhaps for the rest of their professional lives. Elsewhere, where they often hold virtually complete clinical responsibility, they feel that they are being forced to do the work of consultants without being granted either their salary or their status. From both these situations the S.H.M.O. knows he has practically no hope of escape (a) because he has little chance of promotion in his own speciality

and (b) because he dare not move into another speciality as he would have to enter it in one of the registrar grades and would probably find himself unemployed after the training appointment ended.

(2) It is a post without prospects when held in a minor speciality and regarded as carrying some kind of stigma when it is held in a major speciality.

(3) The S.H.M.O., like the whole-time consultant, is denied income-tax relief for car, journals, etc., or a Regional Hospital Board car allowance for journeys from his home to hospital.

(g) The full-time university clinical teacher

67. The Committee notes with regret that no reference is made to the university teacher by the Royal Commission, either in their questionnaire or their public statement; for the maintenance of a satisfactory standard of medical teaching it is essential that the salary scale of the teacher shall be comparable to that of his National Health Service colleague. The Committee is fully aware of the difficulty that must arise in universities if consultants paid by the university do not have financial parity with their colleagues in the National Health Service.

Advantages :

68. (1) An academic life with its opportunities and facilities for teaching, study and research.

(2) Security.

(3) Certain privileges—e.g., it is usually easier to obtain grants to go abroad to study.

(4) A family allowance of £50 per child up to the age of 16 is usually given.

Disadvantages :

69. (1) The clinical teacher paid as a full-time university employee may have a significantly smaller salary than that of his colleague in the National Health Service, even when the type and quantity of hospital clinical work is identical.

(2) He is not granted income-tax allowances for car, telephone, travel, subscriptions to societies or payment for books or journals. He usually has an honorary contract with the Regional Board and must have a car to visit patients and hospitals. He must keep abreast with advances in his speciality and must maintain contact with his research colleagues by visiting them, entertaining them, and attending scientific meetings and congresses. Domiciliary visits are, rightly, few in number in most cases, and only for these and for visits from his main hospital to other hospitals does he have a car allowance from the Regional Board.

(viii) The difficulties encountered by members of the Registrar Grade

70. In the Hospital Service at present there is considerable discontent amongst many of those in the registrar and senior registrar grade.

71. The Spens Committee aimed to secure and maintain a flow of high quality entrants into specialist practice and to concentrate their attention on the work and needs of the hospital.

72. The essence of the Spens proposals was an apprenticeship period within the hospital service of seven to ten years' duration from the date of qualification, at a level of remuneration which would be at least as good as that offered to an entrant into general practice. It was intended that this would provide a modest standard of living without the necessity for supplementary earnings by such traditional activities as coaching, part-time teaching, general practice locums, private assisting and the holding of personal grants during the undertaking of research projects.

73. The Spens proposals envisaged that a person who had successfully completed such a period of training as a registrar and senior registrar could reasonably expect to obtain an appointment in the permanent senior grade of consultant between the ages of thirty-two and thirty-five.

74. It seems also that the Committee intended the registrar and senior registrar grades to be essentially training grades for young men specially selected for such training and that the holders of these posts would not be expected to undertake a large part of the routine work of the hospital.

75. In fact, over the years, it has become apparent that the aims of the Spens Committee were in many ways not practicable and in some ways not desirable.

76. In any profession or business that is to appeal to a man with intelligence and ambition it is axiomatic that where there is a relatively long apprenticeship there must be a reasonable prospect of obtaining a secure position with adequate financial and occupational rewards at the end of the training period.

77. Hospital Medicine does not now offer a reasonable chance of such rewards. The prospects for a man who has completed his time as a senior registrar simply do not measure up to the aims of the Spens Committee. Contrary to expectations, the age of the time-expired senior registrar is frequently greater than thirty-two to thirty-five years; a number of these men served in the Armed Forces during the 1939-45 War and the majority of the remainder completed two years National Service.

78. Much of the serious discontent in hospital Medicine is due to the fact that the number of consultant vacancies in many branches of the profession is greatly exceeded by the number of suitable applicants. Too many well-trained men, many of whom have been doing consultant duties for years under the name and with the pay of senior registrar, are seeking too few permanent posts. The reasons for the lack of consultant posts are several. One is that at the inception of the N.H.S. many of the newly created consultant vacancies were filled by relatively young men and women who still have many years to serve before reaching retirement age.

79. Another is that in the pre-N.H.S. era certain hospitals had local regulations that consultants could only be in charge of wards for a limited number of years. For example in the Royal Infirmary of Edinburgh a man had to retire after being in charge of wards for fifteen years or on reaching the age of sixty-five.

80. Finally, in order to prevent personal hardship and to retain useful trained personnel in the National Health Service, it has become the practice to allow senior registrars who have completed the normal four years in that grade to have their contracts extended. For example in Scotland there are forty-three senior registrars in general medicine of whom fifteen have completed more than four years in that grade and are, in effect "time-expired".

81. Indeed unless circumstances change, only twelve consultants in general medicine are due to retire in Scotland in the next five years. The competitors for these twelve posts will not be only the forty-three senior registrars mentioned above, but will include many applicants from England and Wales. It is obvious therefore that the prospects of promotion for senior registrars cannot be considered "reasonable".

82. At present many posts in the registrar and senior registrar grades are not "training posts", as the Spens Committee intended, but are simply part of a "three tier" system of the medical staffing of hospitals. It could be argued that this is eminently desirable and that the best method of apprenticeship is to carry out what is going to be one's life work under supervision. This argument would carry more weight if the prospects of attaining the security of a consultant post were more "reasonable".

83. The Spens Committee suggested that registrars should devote all their time to the Hospital Service and it has become the practice to offer whole-time contracts to registrars and senior registrars.

84. After nine years' experience of the N.H.S. it has become apparent that this is not necessarily desirable in all cases. The old system by which a man at this stage in his career had to supplement his income had much to commend it.

85. It encouraged initiative and gave wider experience which is so essential in later life for the person who is to become a consultant in the true sense of the word. Another advantage was that if opportunities for advancement in the hospital

service did not occur it was much easier for the individual concerned to change to another sphere, for example general practice. It is fair to say that many senior general practitioners of the best type have been registrars or their equivalent in the early stages of their career.

86. At the present time senior registrars find it difficult to divorce themselves from the hospital service and if they do they suffer from a feeling that they are "failed consultants". In the pre-war era it was widely recognized that such posts did not necessarily lead to consultant positions, as physicians and surgeons at non-teaching hospitals often engaged in limited private general practice. Posts of this type were available for those registrars who found no opportunity for advancement at their own teaching hospitals.

87. There can be little doubt that the principal difficulties encountered by members of the registrar grades are concerned with conditions of service. It is true that as is the case with other members of the population the purchasing power of their salaries is declining and there is considerable financial difficulty for those unfortunate senior registrars with families, who cannot obtain permanent employment in the consultant grade. As they struggle for advancement in their profession they have serious difficulties in maintaining a reasonable standard of life for their families. The dominating factor that is going to have a deleterious effect on the flow of suitable entrants to the hospital service is the lack of reasonable opportunity for advancement for those whose training is adequate and who are well qualified to hold a permanent senior position. Moreover when a man fully trained in this way has spent seven to ten years engaged solely in hospital practice he may feel himself unfitted by training or inclination to transfer to another branch of the profession.

88. The time has come for a critical review of the present conditions of service of the registrar grades in the N.H.S. It seems probable that as heretofore the young man with a brilliant academic future will continue to progress through the clinical university departments rather than through the registrar grades of the N.H.S. itself, but if the hospital service in the country as a whole is not to suffer through lack of recruits a fresh outlook on the registrar problem will have to emerge.

89. With these facts in mind we put forward the following recommendations:

1. The present terms Senior Registrar and Registrar in Medicine which give little indication of the duties of those concerned should be replaced by Senior Assistant Physician and Junior Assistant Physician.
2. The posts at present designated Senior Registrar and Registrar but replaced by the new terms should, in General Medicine, Surgery and Obstetrics be confined to teaching hospitals.

This would automatically reduce the number of senior registrar and registrar posts and bring their numbers more into line with the potentially available consultant vacancies.

It would entail the establishment of more consultant posts in non-teaching hospitals but these would replace existing senior registrar and registrar appointments and the over-all additional cost to the services would not be great.

3. Senior registrar appointments in teaching hospitals, which would bear a much closer relationship to the number of consultant vacancies than at present, could become career posts with an adequate salary and yearly increments for, say, seven years. Thereafter the holders could continue in the post until they obtained a consultant vacancy.

It might be considered appropriate to allow such posts to be held part-time in conjunction with university assistantships or even private consulting practice.

4. Posts at present designated Registrar posts should not necessarily be full time so as to encourage a wider training, particularly in general practice as suggested above.

(ix) The difficulties of entering general practice with special reference to the position and prospects, financial and otherwise, of assistants.

90. Clearly this College, representing as it does the hospital doctor rather than the family practitioner, is not in a position to give detailed information about conditions in general practice, a subject that will no doubt be dealt with very fully by others. Nevertheless there are some pertinent observations that we can perhaps usefully make.

91. Before the National Health Service was introduced there existed a happy relationship and interdependence between those experienced in hospital Medicine on the one hand and those conducting family practice on the other. Doctors of every persuasion were fully conscious of the fact that they belonged to one profession. Now, unfortunately, a schism exists, and the old and pleasant relationship has passed away so that each group tends to operate as a closed community. Worst of all, the gates are all but closed to those who seek to pass from one field to the other. The family doctors and hospital consultants of the older generation look back with pleasure to the easy relationship of the past, but the younger man knows little of this.

92. Formerly it was regarded as an advantage to the general practitioner to have worked for a few years in hospital and perhaps obtained a higher qualification, but in modern times it has come to be thought that the future family doctor is wasting precious time if he does not, at the soonest possible moment, declare his intention to enter general practice. A number of reasons can be offered for this, but the main factor appears to be that selection committees tend to choose the man who from the start has indicated by his activities his keenness to be a family doctor; it must never be suggested that it is a second choice, since that is repellant to existing practitioners. On the other hand we must in fairness say that the Executive Council for the City of Edinburgh states categorically that no such prejudice now exists.

93. The formative years of the family doctor as a student and a house officer are spent in watching and participating in hospital practice, and it is to a hospital that he must refer his more seriously ill patients. When he becomes a general practitioner he may have a feeling that he has lost a certain amount of prestige. This prestige will only be restored when he is more closely identified with hospital work, and the Committee views with sympathy the desire of the keen general practitioner to have a closer contact with hospital practice.

94. It is not possible to generalise about the prospects of the doctor who enters general practice, since these must vary with the individual and be determined in part by the geographical situation of the area in which he wishes to work. The man of character and keenness should have no great difficulty in securing his entry through "apprenticeship" in much the same manner as before, though he will not necessarily be able to obtain an assistantship in the place in which he wishes to practice.

95. Once again we must point out that the whole system as it now operates is much too rigid, leaving little or no scope for a man, who may have developed late, to change his mind.

96. These considerations apart, it should be observed that there are to-day three distinct methods in which a doctor may enter general practice.

1. He may put up his plate in the traditional manner with the important restriction that the local Executive Committees only allow this in under-doctored areas, which in the main are unattractive from the aspect of social amenities and educational facilities.
2. He may apply for an unexpected or death vacancy. The chances of success are remote, since the records show that for the year 1955-56 there were over 950 applications for the 28 advertised vacancies in Scotland.
3. He may become, by private arrangement with a principal in practice, an assistant with a view to eventual partnership.

97. This last method is undoubtedly the one most favoured, since on the whole it offers the best chance of achieving the desired result.

98. The young doctor soon realises that private practice is rapidly diminishing; indeed it is almost non-existent in some areas. This must mean that the orbit of his ambition is inevitably limited to achieving the maximum number of patients permitted under the National Health Service. The average number of patients for whom the 2,551 principals on medical lists in Scotland were responsible at 30th June, 1956, was 1967.

99. The Committee considers it desirable that a new system be evolved to reconcile the advantages of the past arrangements with present ideas and conditions, and has already referred to the desirability of medical registrars being encouraged to do part-time general practice.

(x) The importance of private consulting practice as an incentive to entering the consultant branch of Medicine.

100. In the years preceding the inception of the N.H.S., private consulting practice was the recognized method for the consultant to earn his living and whole-time appointments in hospitals were confined almost entirely to university departments and to municipal and local authority hospitals.

101. Since 1948 the situation has changed. A career in whole-time hospital service is now available for a much higher proportion of non-professional consultants. Such a career has certain advantages and these have been referred to in the relevant section.

102. There is no doubt that to some the whole question of fees per item of service to a sick person is distasteful, whereas to others the stimulus of competition is an incentive and the personal day to day care of patients in nursing homes an attraction. These consultants relish the more intimate contact with family doctors and with patients.

103. There can be no doubt that with the diminishing value of the pound the scope for private practice has diminished. It is said by some that it is diminishing so rapidly that it will disappear in a relatively short time.

104. It has always been recognised that a large private consulting practice was the perquisite of only a few of the available consultants in any one area and before 1948 young consultants had to be content with many "lean years" in the hope of obtaining the very considerable financial rewards of the successful consultant in middle life.

105. Now, given an adequate number of sessions, a consultant cannot be said to have comparable "lean years" once he has achieved consultant status.

106. Some may obtain additional income from appointments as advisers to life assurance offices, banks, the Civil Service or the Treasury, but private consulting practice still remains a definite incentive to the part-time consultant. It is true that there is a considerable outlay involved in setting up and maintaining a consultant establishment, but this is offset to some extent by tax relief and is obviously considered worth while by a large number of those engaged in private consultant practice.

107. With the development of the Nuffield and other provident schemes it seems probable that in the foreseeable future a proportion of the population will still be able to seek consultant advice in private. This proportion will in all probability be enough for the needs of the consultant population, bearing in mind that they themselves have less time for private practice and are now remunerated for their hospital work.

108. In many regions there is adequate provision of private beds in hospitals, but in others, including the South-Eastern Region of Scotland, there is not. Indeed there are no fee-paying medical beds in hospitals in this area.

109. It seems certain that there will always be a demand, although more limited than before, for such a service. It is desirable that this should be recognised and the necessary facilities provided, especially since, with the closure of nursing-homes because of staff difficulties, mainly domestic, the incentive of private practice must inevitably diminish unless suitable facilities for it are provided in hospital.

110. It is felt that this would not be a retrograde step as, provided it is not abused, private practice provides healthy competition among consultants, brings the consultant and family practitioner more intimately together and provides privacy and comfort for a section of the community who are willing to pay.

(xii) Comparative treatment for income-tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service

111. The whole-time salaried hospital practitioner, which includes the consultant paid by the N.H.S., the consultant on the university staff, the S.H.M.O., and to a lesser extent the senior registrar and registrar, all feel they have a genuine grievance about the lack of income-tax allowances for what they regard as necessary professional expenses. These expenses may be summarised under the heads of, car, telephone, medical journals, subscriptions to learned societies, and travelling expenses to scientific meetings.

112. We understand that such expenses are not allowed by most income-tax inspectors to whole-time consultants, though they are allowed, in part, to those consultants who are in private practice. We are also informed that there is a variation in treatment of classes even in the same town, and indeed this must be very difficult to avoid.

113. The rules that define deductible expenses are expressed differently for the two Schedules, D and E. A professional man such as a consultant in private practice is allowed those expenses which are "wholly and exclusively expended for the purpose of the trade or profession". The holder of an office, such as a consultant in receipt of a salary for whole-time duties, is only allowed those expenses which he is "necessarily obliged to incur" and which are spent "wholly, exclusively and necessarily in the performance of his duties". The difference lies in the words "necessarily obliged". The Cohen Commission noted (Command 9474, p. 44), "There can have been no part of the income-tax code which has been so regularly the subject of unfavourable notice."

114. The sympathetic presentation of the case for the professional man by the Commission (p. 46) could hardly be bettered.

"Such persons (doctors, . . . scientific workers) require to maintain and often to increase their professional equipment of knowledge and it must often be quite impossible to relate the expenses of so doing to any specific obligation in performing the duties of a particular period. Their obligation is not only to be skilled in learning but to remain skilled in learning as conditions change. The expenses of so doing are represented by subscription to professional and learned societies, purchases of books and magazines, attendance at conferences, travel for research, purchase of instruments, etc. Yet, under the present rule, the Revenue is forced into making what seems to us rather unreal distinctions between what an employer insists upon and what he does not, between what a person is obliged to do in the performance of his duty and what is desirable that he should do in order to be able to perform his duty: and between current expenses of maintaining knowledge or skill for one post and capital expenses of acquiring improved knowledge or skill to qualify for another post. It is not to be wondered at that the administration of Rule 9 is attended by rather widespread dissatisfaction."

115. The recommendation of the Commission, from which a minority dissented, proposed (p. 47) that the best solution to this tax anomaly was a rewording of Rule 9 on less restricted lines so that there would be allowed under Schedule E the deduction of "all expenses reasonably incurred for the appropriate performance of the duties of the office or employment."

116. The Committee strongly recommends this amendment to the notice of the Royal Commission.

(xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system

117. The Committee believes that in general the method of allocation of merit awards in Scotland is fair and that great care is taken to ensure that no injustices are done. Nevertheless, criticism has been advanced from time to time, mostly against the secrecy employed. We regard this secrecy as essential for the working of such a system.

118. We consider that the merit award system provides a valuable incentive to all grades of consultants throughout their professional careers. We understand that in Scotland 34 per cent of consultants have been selected for this recognition, 4 per cent receiving "A" awards, 10 per cent "B" awards, and 20 per cent "C" awards. The Committee considers these proportions to be appropriate.

119. To ensure that no aspirant for a merit award is neglected, we consider that the Regional members of the Scottish Selection Committee should discuss with individual consultants holding Grade A merit awards the suitability of candidates to fill vacancies as they occur. Such a system would help to dispel any lingering feelings of injustice or omission.

120. Particular care is needed to ensure that no candidate for this form of financial recognition is overlooked. The Committee believes it desirable for the Department of Health to circulate each year all consultants, other than those already in Grade A, with a request for information about themselves in order to assist the merit award selection committee to reach its decisions. By this means all consultants, including those working in remote areas, would have at regular intervals a full opportunity of presenting to the Scottish Committee a personal claim for recognition.

121. It is difficult to see any substitute for the present merit award system which would meet with universal favour and prove more equitable than the present system, which has in fact worked more smoothly than originally anticipated. To substitute higher salaries in selected posts would discourage many men in the smaller and non-teaching hospitals unconnected with the medical schools. At present the award is for the man of ability, no matter where he works within the hospital service. If merit awards were to be abolished it would be necessary to introduce higher salary scales for all consultants than those we advocate (p. 34); the outstanding man would be given no greater financial reward than his more average colleague and the total cost to the country would be greater.

122. Even with this system as at present applied, the Committee believes that there is perhaps too great a tendency to the levelling out of salaries—the difference between the financial rewards of the average consultant and those of the outstanding one is not sufficiently great. It is suggested that for men of exceptional merit in medicine there should be available a small number of merit awards higher in value than the Grade A awards in order that these distinguished men may obtain salaries and superannuation benefits comparable to those enjoyed by the leaders in certain professions and in industry. This spur to ambition would cost the country very little.

123. The Committee would like to comment favourably on the fact that the merit award system is applied in Scotland to chosen consultant members of the university staffs. This helps to ensure that the services of these highly qualified men of great ability, often engaged in specialised research of considerable importance are retained in these university departments concerned with clinical studies.

124. In short the Committee believes that the merit award system as at present applied has much to commend it and should be maintained in the future, with full pension benefits.

(xvii) Special considerations of which account ought to be taken in discussion of medical remuneration.

125. While some doctors may enjoy a regular office routine, there is no doubt that others, whether in general or hospital practice, work extremely long hours, and the growing industrial custom of a shortened week only throws into sharper relief this

overwork. This difference is not likely to disappear. So long as the doctor carries, as he should, a personal responsibility for his patient he will not be happy to shorten his hours by any system akin to "shift" working. Nor can the time not actually spent in practice be wholly devoted to leisure or recreation. All doctors, but especially consultants, have a duty to keep themselves informed of advances in Medicine by reading, study, or by attending medical meetings. Whether he be a general practitioner or a consultant, whether in the National Health Service as a paid employee or with an honorary contract, he is liable at any time of the day or night to have fresh and grave problems put to him for immediate decision.

126. The care of the sick always demands a high degree of responsibility, since an error, whether of diagnosis or treatment, may carry tragic consequences, and this responsibility imposes considerable physical and mental strain. It may here be relevant to note that the mortality experience of the medical profession* is about ten per cent worse than the average for all occupied males.

127. On more general grounds we believe that a good case can be argued for according to the doctor, as to members of the other professions, high remuneration. If we believe that the culture of a nation is sustained and developed from one generation to another mainly by members of the professions, then anything which tends towards the depression of these groups, e.g. financial stringency and lack of leisure must in the long run have an adverse effect on the welfare of the State and at the same time reduce the inclination of gifted persons to enter the professions in the future. For the majority a sense of vocation cannot alone be a permanent inducement to the performance of good work.

(xviii) Specific proposals for medical remuneration

128. We have referred already to the difficulties encountered by members of the registrar grades, and the disadvantages of the present system of S.H.M.O. appointments. We have suggested, further, that the terms Senior Registrar and Registrar should be replaced in Medicine by the designations Senior Assistant Physician and Junior Assistant Physician. The continuing use of the honourable term "Physician" in the title of the aspirant to Consultant status in General Medicine would go a long way towards restoring the self-esteem of the professed trainee, whose closest contact with a register is when, week after week, he eagerly scans the columns of vacant appointments in the advertisement supplement of the *British Medical Journal* or *Lancet*. In referring to the registrar problem we have suggested, too, that registrar and senior registrar posts should not necessarily be full-time.

129. With these ideas in mind we suggest that suitable salary scales, when paid for full-time posts, should be as follows:

House Physician. £500 per annum for the first post held.

£600 per annum for the second and all subsequent posts held.

This title would be applied to provisionally registered medical practitioners holding a post in Medicine.

Senior House Physician. £700 per annum in the first year.

£800 per annum in the second and all subsequent posts held.

These posts would be held by fully registered medical practitioners.

Junior Assistant Physician. £900-£1,350 × £150.

A post obtained normally not less than two years after registration. It might be held normally for four years.

Senior Assistant Physician. £1,500-£2,400 × £150.

This would replace the Senior Registrar grade, but would be a career grade in that the holder, if unsuccessful in obtaining a Consultant post, could continue indefinitely as a Senior Assistant Physician at £2,400. It is envisaged that the title Senior Hospital Medical Officer would be abolished and that he too would become a Senior Assistant Physician, capable of remaining indefinitely in that

* Annual Report, Registrar-General for Scotland, 1955.

post, bearing a title that carried no stigma and yet able to apply for consultant vacancies when they arose. The Senior Assistant Physician would possibly reach the top of his salary grade at about the age of 37 (assuming that compulsory military service was abolished) but could apply for consultant posts before then.

Consultant Physician. £2,700-£4,000 × £130.

As stated before, all consultants would be eligible for merit awards. Part-time consultants would receive a proportion of the full-time salary calculated in a manner similar to what is done at present.

It is recommended that the salaries of clinicians employed full-time by the universities should not differ significantly from those of their colleagues in the National Health Service.

This Committee does not feel that it is appropriate for it to put forward proposals for the remuneration of general practitioners or of members of other branches of the profession whose representatives will be submitting evidence separately to the Royal Commission.

(XX) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.

130. The Committee believes that machinery similar to that recommended by the Priestley Commission for the Higher Civil Service should be used for reviewing medical salaries. This would involve the setting up of a small neutral committee to exercise a general oversight of the remuneration of salaried doctors and to advise the Government either at the latter's request or on its own initiative, on what changes are desirable in their remuneration. While realising the difficulties that would be involved, it is recommended that such a committee should advise on the salaries, not only of those in the National Health Service but also of those doctors employed by local authorities, by universities and in the armed forces.

131. It is undoubtedly in the interests of the public, of the members of the medical profession, and of the National Health Service generally that some form of machinery should be set up for independent and continuing review of the remuneration of doctors.

132. We recommend therefore that there should be appointed a standing advisory committee chosen to reflect a cross-section of informed opinion. We think that such importance should attach to this body that it should be appointed by the Prime Minister, after informal consultation with leading representatives of the medical profession. Such consultation would be essential if the committee were to command the full confidence of the medical profession.

133. Such a committee would necessarily consist of men of high standing, perhaps five in number, including for example Law Lords, leaders of industry and other persons of considerable public standing with a long record of public service, but not members of the medical profession. The members of the committee might perhaps be appointed for periods of five years.

134. It is the obligation of the Government to ensure that members of the medical profession are fairly remunerated, and the introduction of this new machinery would not relieve it of this obligation.

SUMMARY

135. 1. The Committee considers that it is in a position to express views on fifteen of the twenty-one specific topics on which information was requested by the Royal Commission.

2. It draws attention to the possibility that Medicine as a career may be declining in popularity, and stresses the danger to the nation of such a trend.

3. It draws attention to the hardships experienced by Senior Registrars who are unable to obtain permanent posts, and suggests a new system of appointment for junior hospital doctors.

4. It views with concern the growing schism between hospital doctors on the one hand and family practitioners on the other, and suggests a system of part-time appointments for junior hospital staff.

5. It points out the injustices of the diverse ways in which claims for income-tax allowances are treated, with particular reference to full-time medical members of the National Health Service and of University staff with similar clinical responsibilities.

6. It disapproves of the practice of giving newly appointed part-time consultants such a small number of sessions that their income is quite inadequate, particularly in areas where private work is negligible.

7. It gives the reasons for recommending increases in current salaries and makes specific proposals. It stresses the need for "differentials" in salaries. It reaffirms its belief in the value of the merit award system.

8. It recommends the setting up of a small permanent Committee to advise the Government on doctors' salaries.

9. It hopes that, with the co-operation and goodwill of the profession, the Royal Commission will be able to make recommendations which will enable doctors to devote their full and undivided attention to the care of the health of the nation.

Examination of Witnesses

DR. A. RAE GILCHRIST, (*President*)

DR. J. K. SLATER

DR. W. I. CARD

on behalf of the Royal College of Physicians of Edinburgh.

Called and Examined

2871. *Chairman:* Dr. Gilchrist, you will be acting, will you, as principal spokesman?—*Dr. Gilchrist:* Yes. I come before you as President of the College, and I have with me Dr. Card on my right and Dr. Slater on my left. With your permission, it occurred to us that we would divide up between us the responsibility for answering your major points.

2872. Do it exactly as you wish. You will also find questions coming from different directions. Sir Hugh Watson has been chairman of the sub-committee which has been considering this evidence and will be leading off on particular aspects. You will find several of us want to ask questions arising out of your evidence and also other evidence including that of the Faculty from Glasgow, whom we saw yesterday, and the Edinburgh Surgeons we saw this morning, quite apart from those we have seen in England. There are several things which may arise out of what they said. We shall want to question you quite thoroughly on particular points. Please do not misinterpret that as being

in any way hostile, but if we do not question you nobody else will. I would, however, like to start by saying we are very grateful for this very thoughtful and well-prepared evidence, which has helped us a great deal.—Thank you.

2873. We probably will not be asking you quite as many questions as we would have done had we seen you yesterday afternoon because so many points have been covered fairly exhaustively with other bodies. We may be able to concentrate more on a few specific points. Just as a start, perhaps it would help if you explain quite briefly who you are, as it were. We realise that you are representatives of the College.—The Royal College of Physicians dates back to 1681 and over the years one of its functions has always been to do what it could to promote the very highest and best standards in medical practice. At the present time we have approximately 400 Fellows largely, if not entirely, concerned with hospital and consultant practice and we have approximately 1,500 Members. These are accepted as Members of the College, having passed a

professional examination of the highest standard, and it is from the ranks of the Members that the Fellows are elected, mostly having themselves obtained consultant status before their Fellowship. There are exceptions to that rule but for the great majority that is true. Therefore the Fellows of the College have themselves travelled a long way through this arduous training before reaching the Fellowship. I am very glad to have the opportunity to represent them here this afternoon.

2874. You say towards the end of your evidence that you do not feel that it is appropriate for you to submit proposals for the remuneration of general practitioners or members of other branches of the profession whose members will give separate evidence to the Royal Commission. Nevertheless we may want to ask you just one or two questions on general practitioners, since there is no specific Scottish body who has dealt with the problem of general practice; the Scottish bodies have all been Colleges or Faculties.—I do not think, Sir, in speaking for the College of Physicians, we could in any way represent the general practitioners, nor do I think we have any evidence prepared on their behalf. Therefore in questioning us on that topic I think the Commission should take note that it would be individual opinions and views that we express rather than the College's views. We would like to emphasise, Sir, that we are coming to you as representatives of the College rather than individual persons.

2875. Yes, I fully appreciate that, and therefore you will be speaking primarily—in fact almost entirely—for the branch of the profession that leads to consultant status in due course. But at the same time there are certain links with the other branch that lead to matters of interest to both?—Yes.

Chairman: Sir Hugh, would you take over?

2876. *Sir Hugh Watson:* One matter to which the Commission will have to direct considerable attention is the College's attitude to the Spens Report and the question of how far cost of living ought to determine the remuneration of doctors. I notice in paragraph 10 of your memorandum you say that as long as taxation remains at its present high level and inflation continues, it would be impossible for the Government to imple-

ment the Spens Committee's recommendation that the standard of living enjoyed by the profession in 1939 should be maintained, and until this is accomplished the profession has no alternative but to ask the Government to grant such increases in remuneration as are just and practicable. Then in paragraph 52 where you deal with a very important matter—the intake to the profession—you say you would not wish money to be the chief goal of the schoolboy looking to medicine as his possible life work. The Commission have noted your very reasonable approach to this question of remuneration and the very difficult situation which it posed. Would you and Dr. Card like to elaborate on what you said in your memorandum on the Spens Report?—I think Dr. Card would be very pleased.—*Dr. Card:* I think, Sir, that the College feel, as I think most consultants feel, that the Spens Report was a kind of implied contract on which we entered the Health Service. This may not be a contract in the legal sense: it may not be enforceable. We are not lawyers and can only work on a general agreement. That is I think how it appears in our eyes, and since the Spens Report clearly envisaged an adjustment in terms of present day money values, and since this report was the basis of our contract, we felt the Government had a duty to increase the remuneration of doctors as the pound depreciates. If we made the assumption that the depreciation of the currency is entirely the sole responsibility of the Government, presumably they should increase the remuneration of the doctor entirely, but the College do not take that view. We are not economists: we can only express a kind of layman's view; and we feel that the circumstances of post-war rehabilitation of Britain was so difficult and so complex that it would be hardly reasonable to ask the Government to assume entire responsibility for the fall in currency which in fact has occurred. We feel however that the Government must accept considerable responsibility, and it is therefore only just to claim some increased remuneration to balance part of this. I think our case would rest on the assumption that the Spens Report accepted by Parliament and by the profession was a kind of implied contract.

2877. Of course the Spens recommendation was to the effect that the remuneration of doctors should have direct

regard to the value of money and to the changes in the incomes in other professions?—I think that is so, Sir, yes.

2878. I do not know if it is fair to address you on this, Dr. Card, because as I have said the Royal Commission feel that your presentation of this matter is very reasonable indeed, but would you suggest as has been suggested elsewhere that the medical profession should be insulated against the cost of living?—I do not think doctors or any other part of the community could claim a kind of special insulation in that way. I think our case would rest on the fact that we have given up all our freedom of practice to enter the Health Service on the basis of the Spens Report, and in doing so we feel the Government have in their turn a kind of contractual obligation. As a doctor I have no more special claim than anybody else. A doctor only has it in relation to this historical fact that he has given up all freedom in order to enter the Health Service.

2879. *Chairman*: You would feel that a doctor should not be alone in being insulated from the effects of inflation. On the other hand you would not like medical remuneration to be a means of holding everybody else down.—I think that is right, Sir, yes.

2880. *Sir Hugh Watson*: You know, Dr. Card, the terms of reference of this Commission, and you know that the Commission has stated publicly that it will have regard to the Spens Report. But of course its terms of reference are quite independent and they do not themselves incorporate reference to the Spens Report?—No, Sir.

2881. Would you agree with me that the Spens Committee were undertaking a very difficult task in advance of a situation which they could not fully envisage?—Clearly they could not fully envisage it.

2882. And it could be that the events which have happened since then and the smoothing down of what might be called the teething troubles incidental to the inauguration of the National Health Service might cause a different view to be taken about the whole thing?—I think there would be differences in detail, yes. I think there would be bound to be some differences in detail.

2883. Of course you know that the Spens Committees directed themselves to ascertaining what was the appropriate

income in 1939 and in their classic expression they left it to others to determine what was the then level in the cost of living. Spens went no further?—Yes.

2884. Then there was Danckwerts: now there is this Royal Commission; and that is the position today. I gather from what you say in your memorandum that you are prepared to ask the Government to grant such increments in remuneration as are practicable?—That was the general phrase we used, yes, Sir.

2885. If I may say so, Sir, I think that is a very reasonable and intelligible way of looking at the situation. Could we pass to another subject? In paragraph 14 you deal with a matter on which we have had a good deal of evidence—the cost of education and training and the assistance given by way of bursaries and grants. You do point out in later paragraphs that there is a disparity in this matter between England and Scotland. I would suppose that appropriate representations could be made in the appropriate quarters to have these matters dealt with?—*Dr. Gilchrist*: As I understand it, Sir, it was put to the Committee forming this report that there was a difference of approximately £15 in the grant available to the English schoolboy and the Scottish schoolboy.

2886. *Chairman*: In paragraph 45, Dr. Gilchrist, you point out that an English student at Edinburgh can receive under the English regulations £30 more a year, but that the Carnegie Trust can make up some part. They quite often make up a part.—I do not think—here I am not on absolutely certain ground—the Carnegie Trust grants are extended to people other than those born in Scotland or the sons of Scottish parents. I do not think a boy coming from England would necessarily be eligible for a Carnegie grant. I am not quite certain on that point, Sir.

2887. I think you said the boy coming from England in any case gets more?—He gets more from his local authority but I do not think he would be entitled to get anything from the Carnegie Trust.

2888. *Sir Hugh Watson*: That is quite right, Dr. Gilchrist. As a Carnegie trustee I can tell you you are quite right. May I draw your attention to one thing

that has been mentioned in paragraph 45? In the second last sentence you say:

"On the other hand the Scottish student in poor financial circumstances may have his university fees paid in whole or in part by the Carnegie Trust, even if he is in receipt of a maximum local authority grant."

That is not now so. At their meeting a fortnight ago the Carnegie Trust announced they had changed their policy in that regard. They will now have regard to exceptional cases of that kind. In general cases they will not pay the fees of a boy who is getting a full local authority grant. They will give grants also to persons seeking higher qualifications. It was not given sufficient publicity in the press.—I am very grateful to you for pointing that out. I had no idea the Carnegie Trust was so generous as to support the claims of the post graduate.

2889. This is a new policy.—Yes, thank you.

2890. *Sir David Hughes Parry*: The student from England may not be supported in the same way by every local authority. Some are more generous than others. Therefore it is rather difficult to generalise about a grant coming from a local authority to an English student. It will depend on the local authority? —I think it is the right answer to say that some of the English local authorities are a little more exacting after the student has graduated in that some of them demand the repayment of the funds that have been advanced to him. I have known that.

2891. In the past? I do not think in recent years?—Within the last ten to fifteen years—ten at any rate.

2892. Not in the last few years?—No.

2893. *Chairman*: You do conclude in your paragraph 46 that you do not feel that real hardship has been experienced by medical students or that financial difficulties prevent any really suitable student from becoming a doctor?—I think that is true, Sir.

2894. *Sir Hugh Watson*: Dr. Gilchrist, in paragraph 15, passing on to another slightly different topic, you deal with the accommodation of the newly qualified medical graduate and in particular of the house officer. Some criticism has been

made to us about the practice in the sense that the house officer is compelled to live in, is charged for his board and lodging and is charged all the year round, even during his annual leave. Does that come in your knowledge as something that causes annoyance?—Yes, that is true. I think there are many young men who resent that very much.

2895. You know of course this payment was a matter of agreement with the Whitley Council. It is an agreed payment and represents substantially less than the actual cost of the board and lodging provided. How would you suggest this matter should be dealt with? —I should have thought that in many hospitals the young man newly graduated could quite well be supported without a charge, without a deduction from his salary. I think the charge is not very high. I think it is probably about £150 a year.

2896. £2 10s. a week?—I think it seems rather strange to take that amount from this man. After all what is their salary—£500 a year and we proceed immediately to deduct board expenses. When I was a resident I lived in the Royal Infirmary and was very well looked after. I was not paid a penny but nothing was taken from me—for my board and keep.

Sir David Hughes Parry: There was nothing to take it from!

2897. *Chairman*: Again it has been put to us by other bodies that there is a need for a relationship between the total earnings immediately after the house officer period of those going into general practice in normal ways, for instance as assistants, and those coming up to the position of senior house officer, so they can change from one side to the other without their earnings being greatly affected. Now if the relativities are to be really comparable would it not rather complicate matters if the salaries in one case were wholly in cash and in the other case partly in cash and partly in kind? That is, after the first year? —That is a little difficult to answer, Sir. I had not thought about that frankly. I know there are those who believe the registrar should be rewarded on a basis equal to the young man entering general practice, but the registrar lives as a general rule out of the hospital and

there are no deductions from his salary for board and lodgings.

2898. And the senior house officer?—The senior house officer, as I understand it, on account of his higher salary I think has a greater amount deducted for exactly the same facilities, the same upkeep and so on as the man junior to him. I do not think the senior house officer could be regarded as being in competition with the man—I mean from a salary point of view—who has just gone into general practice. I only say I think he is more junior.

2899. *Sir Hugh Watson*: He would be comparable to a trainee assistant?—Yes, I would say comparable roughly to a trainee assistant.

2900. The remuneration of a trainee assistant we understand is £850 a year.—I do not know.

Sir Hugh Watson: I think that is so. I think you may take that.

2901. *Chairman*: And that of senior house officer is £820. There is not much there.—That is a proportionately reasonable amount.

2902. Supposing the senior house officer was paid £600 plus full board and lodging, that would make it more difficult to make a comparison. Would you feel it right at the senior house officer stage that there should be salary and deduction rather than lower salary and no deduction?—I think so.

2903. It is at the junior house officer stage that you are on balance in favour of the lower payment with no deductions.—That is right.

2904. It is a psychological point?—Yes.

2905. I think the other source of irritation is that the young people coming into residency in the hospital grudge that X should be taken off their salary, whereas the senior house officer has X plus deducted; and another man who may be a hospital medical officer giving anaesthetics or something of that kind and who earns a bigger salary has a greater amount taken off. What causes friction I think is they all have the same facilities, all mess at the same table, and yet one man has a greater deduction from his salary than another.—I think that is true.

2906. *Sir Hugh Watson*: One does not want to go back and compare what happened in what were in some ways perhaps the bad old days, but you did mention when you were a house officer you were paid nothing at all. But one of the objects of the Spens Committee Report was to ensure that that state of matters was altered, was it not?—Absolutely. I am not suggesting the Royal Commission might care to incorporate that system in future!

2907. The Spens Committee recommended that in a public service the specialist ought not at any stage of his career to require to supplement his earnings by private means?—That is true, and we strongly support that view.

2908. *Chairman*: In the old days, taking an allied point, in the peripheral hospitals where there was no teaching the junior house officer probably would have received a salary?—Yes, in those days the common salary was £100 a year.

2909. You did not get that salary if you went to one of the teaching hospitals because you got the extra advantage of the teaching?—In those days there was—and still is—a very considerable prestige attached to such an appointment. He is usually a picked man who goes into a teaching hospital because he has shown himself to be a man of ability. The teaching hospitals therefore in the old days could pick the man they wanted without the necessity of offering even a mere pittance for salary. The smaller hospitals as a general rule—the provincial hospitals and peripheral hospitals—even in those days had to offer something.

2910. Is the position in Scotland as it is in some other places, that there is a queue of people willing to be house officers in the teaching hospitals, but in some of the more remote peripheral ones it is very difficult to get anyone?—I believe that to be true, yes, because the men realise themselves that it is an enormous advantage to be a house physician or surgeon in a teaching hospital.

2911. Such a position is probably not in the best interests of the patient or the service. Have you any suggestions to make as to how one could get the peripheral hospitals more fully staffed?—Yes. We have some suggestions on that, Sir. One of the suggestions is that in the peripheral hospitals a number of

senior house officers should occupy the most junior posts, house physician, house surgeon, and so on. In other words, that the junior staff in the peripheral hospitals might be reinforced by senior house officers who had previously been in a teaching hospital for their first job, who would go out to the periphery some distance away with a year's experience, either in medicine, surgery or obstetrics. They would then approach their work with greater confidence and experience in areas where they are much more isolated and have not the advantages of the full consultant team.

2912. Do you think it should be to any extent a condition of service when young doctors are taken on for their junior house posts that they should do a further year as a senior house officer in a peripheral hospital?—I think that would be a helpful thing. I would not like it as a regulation but as a recommendation. I do not think people should be forced to do these things, but those young men available for a second year of hospital training might well be encouraged to take posts as senior house officers in the peripheral hospitals. I think that would be greatly to their advantage. I think it would be to the hospital's advantage too because they come with a better grounding of practical experience and a measure of confidence.

2913. Have you any rough idea as to the number of peripheral house officer posts compared to the number of teaching hospital posts? Would they be near enough in balance?—I would find that difficult to answer just immediately. I do think we could find that for you but I cannot answer off the cuff.

2914. You think they would be near enough in balance for such a system to work with justice?—Yes.

2915. *Sir Hugh Watson*: There is a small point in paragraph 18, Dr. Gilchrist, where you point out the difficulties of getting into general practice, with which the Commission are now fairly familiar. I think there is a slight misunderstanding in one of the figures here. You say:

"According to figures prepared by the British Medical Association, the average gross annual income of a general practitioner in 1956 was approximately £3,000, yielding after

deduction of practice expenses an average annual net income of £2,222. In Edinburgh, however, of the 258 general practitioners on the list of the N.H.S. Executive Council 65 (25 per cent.) had an annual income from the service of £1,000 (gross) or less."

The figure of £3,000 is a composite figure, is it not?—Yes.

2916. It is not only the income from the service: it not only includes income from temporary residents, initial practice allowances, mileage, maternity services, training grants and all the rest; it also includes income from work for local authorities, hospitals and various types of private practice. It is a small point. I do not think the two figures are comparable really. You see what I mean?—Perhaps not.

2917. I do not think it matters very much, but as it stands it gives a slightly misleading impression.—I would say, Sir, that these figures were supplied to us by the Executive Council of the National Health Service in Edinburgh.

Chairman: The figures are correct, but I do not think we are comparing like with like.

Sir Hugh Watson: That is the point.

2918. *Chairman*: You know of the inquiry we are making from a large number of doctors about their actual earnings, and you may know that we have already had an extremely good response. A high proportion of doctors have already answered. That will help to get accurate figures that are comparative.—Yes, Sir.

2919. *Sir Hugh Watson*: Passing on to something more important, Dr. Gilchrist, which you deal with in paragraph 19, under the heading of "the registrar grade". We have had a good deal of information given to us from various sources about what has been described as the rigidity which now obtains in the two branches of the profession, and the difficulty of transferring from the hospital service to general practice and vice versa.—I appreciate that, yes.

2920. It has been suggested to us that some of that difficulty has been brought about by the profession itself, and that the profession itself could to some extent take steps to make it more easy to overcome. We understand, for instance, that among Executive Councils which have to

deal with vacancies in general practice there is what amounts to almost a prejudice about appointing to a practice a man who has been for some number of years in the hospital service. Is that within your knowledge?—It certainly is, yes.

2921. Would you think on the other hand that it is probable that a man who has had an appropriate number of years of hospital experience quite possibly would make a very good general practitioner?—He makes the best general practitioner. This is one of the great faults, as we see it, this divergence—this splitting of the profession into two watertight compartments so as to have the hospital service on the one hand and the family doctor and general practice on the other. It has long been the custom before the Act, not only in our teaching hospital here in Edinburgh, but also in London and elsewhere, that men served in what would correspond to the present registrar grade in hospitals and at the same time for a year or two had a footing in general practice often with a general practitioner of the highest standard. Such a practitioner found it greatly to his advantage to have the assistance of a young man who was thoroughly familiar with the current hospital outlook. These young men, when they went into general practice, as many did here in Edinburgh, usually built up the best practices and did the best work. That we attributed largely to their contacts and experience with the hospital. I think many people in the hospital found it likewise, that contacts with practitioners outside were to the good of both parties. I would like to emphasise that.

2922. You suggest towards the end of paragraph 19 that it would be desirable to have registrars part-time in general practice while working in hospital?—Yes.

2923. It has been suggested to us by others that registrars should work an equivalent of seven or eight sessions; they could then also be doing research work in their other time in the laboratory or elsewhere; they could indulge in teaching and enlarge their scope. Do you think this would be desirable?—Yes, I would very much think so, but I do not think it should be too rigid. You were speaking a moment ago about the rigidity of the service and I think that

one of the great advantages of work in medicine in the days before 1948 was that it gave much greater scope to the young man to exercise individual freedom. There was one type of registrar who preferred individual work with patients and wanted to cultivate general practice; well and good. But you have to make allowances for the other type of man who has a much more scientific outlook, the man who would like to cultivate along with his registrarship work in biochemistry, physiology or one of the other basic sciences. Therefore I would say you must encourage the man, giving freedom of choice. Part-time service for the registrar should be on a voluntary basis. Compulsion would put people against it. There must be freedom of choice.

2924. *Chairman*: The needs of the service must be the paramount consideration?—Yes. I am certain this would be to the good of the service. The hospital service will benefit by the man who has a scientific approach. The hospital service will benefit by the man who has the purely individual patient approach. Medicine covers such a wide ground, I think you have got to allow freedom of choice at this stage in a man's career. These are the formative years, the years when that man's future is being determined. He should be allowed to go his own way according to his own inclinations, doing those things he finds he is good at doing. You must not, for example, make him go into a laboratory against his inclinations.

2925. *Sir Hugh Watson*: You will be glad if he has an opportunity of doing these things?—Absolutely.

2926. Possibly also you would agree the advantages of doing these things should be pointed out to this young man. —He works under the direction of the consultants, and I am sure he would get guidance from his "chief".

2927. *Chairman*: I suppose one of the main difficulties that enforces a measure of rigidity is that one branch of the profession is a basically salaried service and the other basically is not. That is one of the things that have separated the two branches into two watertight compartments, is it not?—I suppose that is a fact; I think that is true. But I would think that the rigidity which exists in the division between the two

branches is largely, or in part at least, the result of the architecture of this Act. I feel sure it goes back to the Spens concept that the young man without private means should not be left to struggle or flounder if he were a man aiming at consulting hospital practice. Spens came along and offered these men salaries in this rigid way and that has, I think, been the means of divorcing them from their contacts with the other branch of medicine which would be so much value to both sides.

2928. *Professor Jewkes*: In paragraph 92 you suggest that "the main factor appears to be that selection committees tend to choose the man who from the start has indicated by his activities his keenness to be a family doctor". Does that mean, in your opinion, that the selection committees are really pursuing a policy that is not linked with the technical efficiency of the service or concerned directly with the interests of the community?—I would say that certain Executive Councils have, for some reason best known to themselves, felt that the man who has had an extra year or two of hospital experience—the man who perhaps has done his original year, perhaps has been a senior house officer for a year, perhaps has been a registrar for two years—was not best suited for general practice. That is an attitude that we have found difficult to understand. In fairness I must say that when the Executive Council of this city were approached on this subject by the College, they stated categorically that there was no such prejudice in their minds. Yet, on the other hand I have known instances of registrars in the hospitals here in the neighbourhood who have found it very difficult to get into general practice.

2929. *Chairman*: It would seem, Dr. Gilchrist, that if this reduction in the rigidity is to be obtained, the profession itself has got to do a bit of work. The Executive Council and the Hospital Board perhaps pull in different ways to some extent, but it is for us to try and provide scales of payment or methods of remuneration which will make it possible to lessen this rigidity. Is that your view?—Yes, in a measure I think it is. Yet at the same time I personally would hope that the Royal Commission would make recommendations regarding the difficulties of registrars and senior

registrars because that is, to my mind, one of the most serious problems confronting the profession at the present time. It is true that this problem has been under review by the profession for the last five or six years, if not longer. Within the last two years, I think I am right in saying, the Joint Consultants Committee has had at least ten interviews with the Minister of Health on this subject, without making any substantial progress. I think it is an aspect—a facet—of the service that the Royal Commission, if I may say so without any disrespect, can hardly afford to pass over. I do not think it is entirely the profession's fault. The profession has been doing a very great deal over the last five or six years to try to correct this situation, and it is proving almost an insuperable problem. I would like very much to have the opportunity of saying something about the registrar problem if any question arises on it, because the College has given very serious thought to the problem and we feel we do have something in the nature of constructive proposals to offer.

2930. *Sir Hugh Watson*: Shall we examine the matter now? I think the Commission fully agree with you; it is a very important matter indeed and quite differing views have been expressed about it. In the first place, would you agree with me that at the moment there is a somewhat sad situation with regard to the registrars because of the inordinate intake between the years 1946 and 1952?—Yes, I think that is so.

2931. It has been put to us that the registrar situation has been aggravated by an excessive entry of registrars into the hospital service between 1946 and 1952. Also it has been represented to us that the consultant establishment requires to be reviewed—in other words, that there are not enough consultants?—Yes.

2932. What we would like to know is this. In your view is there a shortage of consultants having regard to the needs of the service, or is there a shortage of consultants having regard to the desirability of finding places for frustrated registrars? You see what I mean?—Yes, I do very well. I think there are shortages on both grounds. I think there is room for more consultants in many hospitals, particularly in the peripheral hospitals. I think that it is also true to

say there is a bottleneck in registrars and senior registrars, and I believe these men ought to be absorbed as consultants at an early date.

2933. The Chairman asked a question this morning to which he did not get an answer. Perhaps you can give the Chairman the answer. The question was very simple. What is a consultant?—May I direct you to our paragraph 21 which opens:

"The consultant is a man of experience . . ."

2934. What is the consultant's work then, doctor?—A consultant is a man of experience. I think that is the first point.

2935. *Chairman:* The point is, Dr. Gilchrist, we have heard many times the statement that senior registrars are doing consultant work and should therefore have the status of consultant. We wondered whether there is a definition of what a consultant's work is?—I think I can tell you, although there is some difficulty in defining it. I think I can offer some explanation of what a consultant does in the hospital service. He is in charge of a ward or maybe several wards—a large number of beds. He is as a rule head of a team and his is the responsibility, the final responsibility, for the care and treatment of the particular patients in his charge. That is his main function, the care and supervision of the patient. He has other duties. He has teaching duties, particularly in the larger hospitals. In Scotland he has very important teaching duties. Secondly it is part of his work to inspire and encourage and foster the welfare of the undergraduates. He will take an active part in encouraging clinical investigations of one kind or another. He often does a great deal nowadays in the direction and administration of a hospital. He serves on endless committees, the Board of Management of the hospital, and so on. He is in fact in the top rank of the hospital service. I think I can best explain it on these lines.

2936. You see the point is that there is a very great difference between the top remuneration of a senior registrar, and the top remuneration of a consultant, leaving aside merit awards. For the senior registrar this remuneration is £1,540, for the consultant it is £3,255.

So there must be, to justify the difference in remuneration, a very sharp difference in the type of work undertaken.—On the one hand you are rewarding a man of experience who has devoted his life to this work: on the other hand you have a man who is in training for this work who has served in a hospital and who is gaining experience. It has always been the intention to promote to consultant rank men from the senior registrar grade. It is a stepping stone to the higher ranks in the service. I do not know whether I am making myself clear or whether I am answering the question you are putting to me. I am not sure that I am.

2937. I think the difficulty is that there is clearly a difference of opinion between the employing authorities and among consultants as to whether certain senior registrars are or are not being used, as a means of dilution, to do consultant work?—I think it is true to say that there are a number being so used. You must not press me on the exact number, but I think it is true to say at the present time there are a number of senior registrars—some of them perhaps time-expired registrars if you like—who are undoubtedly doing consultant work. I think that is a fair statement.

2938. From your description I would think it quite likely a man could in fact be doing senior registrar work together with a certain amount of work that goes into what you call the consultant sphere?—I think that is true.

2939. There may be such cases?—There may be such cases. I think it is fair to say that, yes.

2940. But under the present system he is either a senior registrar or a consultant, and in the one case, not only does he get a much smaller rate of pay, but he is unestablished?—That is true. He gets a smaller rate of pay, is unestablished, has no security for the future and is a highly trained man. But in many instances I think it is true to say that the hospital could hardly run without him. I am sure that is right. It is no fault of his own that he is not admitted to consultant status.

2941. It may or may not be?—But it does not necessarily mean if he is a time-expired registrar that he is not of the quality to be a consultant.

2942. *Sir Hugh Watson*: In other words you would contemplate that not every registrar should automatically become a consultant?—No, I would not.

2943. *Professor Jewkes*: Not every senior registrar?—Not every senior registrar. The staffing of the hospital has always been in a series of tiers with more house physicians than can become registrars, more registrars than can become senior registrars and more senior registrars than can become consultants. It has always been competitive to move from one stage to the next: that is perfectly true. And that is where the hospital gains its strength because it has always been picking from each grade the best man for the job.

2944. *Chairman*: There is a competitive element?—There has always been a competitive element, and I would contend that that competitive element has always been to the advantage of the hospital service: it has stimulated progress.

2945. *Professor Jewkes*: Now that you have defined a consultant for us, could you help us define what you mean by a shortage of consultants? By what kind of objective test would you be in a position to say there is a shortage of consultants?—I suppose really a shortage of consultants in any particular hospital would be shown by the amount of work the existing consultants have to do. I know instances—and I am not referring to Edinburgh—of a consultant in a job which has been established. He does not have an assistant consultant; he is an isolated consultant, and he does not have what we called in the old days an assistant physician. His is the entire responsibility as a consultant, and he works from morning to night seeing patients in hospitals, and travels from one hospital to another. He is a thoroughly overworked man in that he has no leisure, no contemplative hours are open to him. That may be to the good of the hospital service, but it is not to the good of that particular consultant. It is very much to the discredit of Regional Boards that they have not done more to help in this respect.

2946. Are there plenty of candidates who have the necessary experience and qualifications to be consultants to fill these gaps?—At the present time—I am speaking entirely for myself—I would say that in Scotland we have admirable candidates amongst the senior registrars.

2947. *Chairman*: May I interrupt? I want to get clear what you are saying—you are surprised at the Regional Boards not appointing more consultants?

—In some instances, yes. I would say in my opinion there are in the hospital service at the present time senior registrars and time-expired senior registrars of very high quality, and well worthy of becoming consultants. Many of them have in fact had, better training for the appointment of consultant than men had previously to 1948; and yet these men are not being absorbed as they ought to be in large numbers.

2948. *Chairman*: Is that so in most of the hospitals?—I am not thinking of hospitals; when I am speaking of this topic I am speaking of general medicine in particular. I would not like to come forward and say that applies to all specialties.

2949. *Mr. Watson*: Is there any real evidence, Dr. Gilchrist, to prove that the registrar is receiving a better training since the Health Service than he was before?—Do you mean is there any documentary evidence?

2950. Is there any real evidence?—This is a matter of opinion. I have spent my entire professional life in the hospital service; I was appointed consultant in 1930, and I can say from my own experience that the training which the registrar and senior registrar gets now is better than it was in the old days. Does that answer your question?

Mr. Watson: Yes, thank you.

2951. *Sir Hugh Watson*: You have made one suggestion in your paragraph 20 for dealing with these senior registrars. You suggest what is in effect the interpolation of an intermediate grade of Senior Assistant Physician or Senior Assistant Surgeon.—I am glad you have brought this up, because we have been misrepresented and I am glad to be able to correct any false impression. If I may say so, when we are speaking in paragraph 20 of Senior Assistant Physicians—I think it is paragraph 20 you are referring to...?

2952. Paragraph 20 and 89.—We would like to make it clear that when we say Senior Assistant Physician we are really referring to the senior registrar. The suggestion we are making is that the titles of these posts should be altered, not that the work should be altered, not that

the man's status should be altered necessarily. But instead of calling a man a senior registrar he should be called a Senior Assistant Physician or Senior Assistant Surgeon, and so on. The Junior Assistant Physician or Junior Assistant Surgeon would then correspond to registrar. I am glad to be able to emphasise that, because we are not suggesting what has been called a sub-consultant grade—we are not doing that.

2953. I am glad you have made that so clear.—I want to make it perfectly clear.

2954. In the middle of paragraph 20 you suggest the senior registrar post should become a permanent one with a higher maximum salary and a new title. That is objected to by your friends across the border in particular because they say that would add to, rather than diminish, the sense of frustration from which these men suffer. These other bodies say that senior registrars would then feel more than ever that they had got to a point beyond which it was probable they might not advance further. Do you see the criticism?—I see the criticism. I would like to say that in putting forward these recommendations to the Royal Commission we are not suggesting that they should apply to the hospital service in England. The Royal College of Physicians has applied itself to the problem in Scotland. We make no apology for doing so because as you know there are two Health Service Acts—one applies to England and the other to Scotland. There are differences in the arrangements, differences in the administration, the chief of which is that the teaching hospitals in Scotland are under the aegis of the Regional Hospital Boards. In other words, all the peripheral hospitals and teaching hospitals in Scotland are under a Regional Hospital Board with the teaching hospitals as the focus, and the peripheral hospitals round about. That is not so under the English Act. Under the English Act the teaching hospitals are in direct contact with the Ministry and are not under the supervision of a Regional Board. The Regional Boards in Scotland are entirely responsible for the teaching hospitals. Here we have a different situation, a different kind of administration, and the suggestion we make on the basis of that, the adjustments in the registrar situation and in

the senior registrar situation, are made with the Scottish conditions in view. To change the status of the registrar or senior registrar in the peripheral hospitals in England, hospitals in the big centres of population, such as the Midlands, might cause very considerable embarrassment. There, what we would call peripheral hospitals do function quite independently and are often divorced completely from the teaching hospitals and the University centres. That does not apply in Scotland, because each Regional Board with the exception of the Northern region, is really based on the University medical school.

2955. Am I right in thinking also that in Scotland there is something which was described to us I think yesterday, as a tier system?—Yes.

2956. You have a recognised chief?—That is right, a man in charge, yes.

2957. Am I right in thinking that does not obtain at least to the same degree in England?—I should have thought it was very similar in that respect.

Sir Hugh Watson: I am probably wrong about that.

2958. *Sir David Hughes Parry:* In the Scottish set-up there is a consultant, and is there another consultant under him?—Yes. In the teaching hospitals the Scottish tradition has always been—I am talking of the time previous to the Act—that you had a consultant in charge of wards in charge of a department. He had his own wards, his own beds, and he had with him an assistant physician, also a consultant, who worked with him and in association with him, and who was responsible for the out-patients, and so on. They both shared the teaching. Then, junior to them, we had what we call in Scotland a clinical tutor—clinical tutor corresponds to the senior registrar, and below him was the house physician. That I think was the set-up.

2959. The set-up in some hospitals in London at any rate is that each consultant in the unit has a number of beds and is entirely independent within the unit.—That has never been so in Scottish teaching hospitals, although I think that rigid rule of the past is breaking down, and probably rightly. In the past a ward, the whole ward, was in the charge of one man, who accepted the clinical responsibility for every patient. That, I think, is breaking down, and

what corresponds to the assistant physician is being given more and more responsibility by his chief, by the consultant. He has not been allocated beds by the hospital Board of Management, not yet, but I think that time is coming. There is little distinction; at the present time as the assistant consultant he receives beds by way of courtesy through his chief.

2960. When you were defining the consultant earlier on, you said he was the head of a team?—That is right, and so he is.

2961. If he is an assistant physician he is not the head of a team?—There is a confusion about this, and I am trying to clear the matter for you. I have been telling you of the system that existed before 1948. You had a man who was given, by the Board of Management of that teaching hospital, the responsibility for that ward, and the beds and the patients in it. He had associated with him a consultant who shared that responsibility with him to some extent, and also was responsible for out-patients, and so on. They both taught together. They, with the clinical tutor and house physician, formed the team. At the present time in Scotland there is a tendency, although so far as I know it has not been necessarily put into action by Boards of Management, for the assistant physician or assistant consultant to be given beds as of right.

2962. That is quite clear, yes. Not every consultant is yet the head of a team. He is in a team, but not necessarily the head?—That is true; every consultant is not necessarily the head of a team.

2963. *Chairman*: In that respect there is some similarity in Scotland with the English system?—Yes.—*Dr. Card*: I think the point *Dr. Gilchrist* makes is that the assistant consultant or physician should be given beds in his own right, and not as an act of grace. In a particular hospital the Board of Management has in fact given beds to the assistant, but it is a thing which is not general in Scotland. In England there used to be this position. The assistant chief—there is always a chief and assistant chief—would be given beds, and he had them in his own right. In my own hospital before the war the assistant chief was given ten beds as assistant physician.

2964. *Sir Hugh Watson*: May we move on to a point allied to the subject which we have just been discussing? You told us your views about Senior Assistant Physicians, and so on, and then you go on in paragraph 129 to deal with their suggested remuneration. Would you like to expound this to us? Have you something in mind here?—

Dr. Gilchrist: What I had in mind was in regard to the unfortunate plight of the registrars and senior registrars at the present time. What I really want to do is to expand some of the recommendations that we made in regard to these men. My own feeling is that the standards of care and attention in the hospital service are likely to suffer if the current bottleneck in the promotion of senior registrars is allowed to persist. I think the hospital service will suffer, and I think the standards of practice will also suffer in the long run, for there is already evidence that the number of men coming forward for registrar appointments is falling off. We have very definite evidence of that. The number of our own graduates—it does not merely apply in Edinburgh, but in other teaching centres, notably Aberdeen and elsewhere—the number of our own graduates coming forward for appointment as registrar is now falling rapidly. That means men of high quality are not presenting themselves. It means that in the future when senior registrars are wanted there is not going to be the same choice. It means ultimately, if there is not the same choice for registrars, there will not be the same choice for consultants. The whole service will suffer if the registrar-senior registrar problem is not put right. The fact is at the present time men from the Dominions are tending to occupy the registrar posts in the hospitals in this country. Many of them are excellent doctors, but they may be registrars for two years or thereabouts, and then return to Australia, New Zealand, India or Pakistan. In other words, they are receiving their training in the hospitals of this country at the expense of the British taxpayer; and having completed their service as registrars, with great advantage to themselves, they then return to their home countries. They give excellent service in the hospitals, but that is not what these posts were designed for. The hospital service is going to suffer in consequence. I know that as a fact from

my own experience. Something has got to be done to try to correct this bottleneck in registrar-senior registrar appointments.

2965. *Sir David Hughes Parry*: You were saying two things—there are fewer applying, and the quality is not as good?—I am saying there are fewer of our own graduates applying for registrar appointments in the teaching hospitals of Scotland. Therefore in five, ten, fifteen or twenty years when consultants have to be appointed, the men available will not be so representative; there will be a smaller group who will not have had the same experience.

2966. I think it is not so much the number applying that really matters, as the quality of those who are appointed. It may be they have shed the bottom element entirely on the way, and that might be quite a good thing?—They have shed them at all levels. I can say that only last week for a registrar appointment there was not one applicant; I can say that also in Aberdeen there were three vacancies for registrars and not a single Aberdeen graduate applied—in fact not a British graduate applied.

2967. Is that a teaching hospital?—Yes, a teaching hospital. If that continues, then obviously, when the time comes to promote people to senior registrar, you have a smaller choice. Many of them, excellent men, come from the Dominions and tend to go back there. Therefore the choice for a senior registrar post is reduced, and will be reduced further.

2968. I would like to get this clear. You said before that fewer were applying, but you implied that still a number were coming forward; now you say that practically none are applying.—I say the number of our own graduates is constantly and steadily falling, and very naturally the best people are not going to apply to get into this bottleneck. The chances of promotion in the hospital service are remote, and the chances of getting into general practice are poor, and therefore they are not applying. That seems reasonable.

2969. *Chairman*: And it is with this very much in mind that you are proposing this new scale?—That is right; we are making here a suggestion to try to correct this. The prospects of promo-

tion of senior registrars in Scotland at this present time are deplorable. I would like to take this opportunity of drawing the Commission's attention to an article in the *British Medical Journal* of December 14th, 1957, by Dr. Hamish Watson on the promotion prospects of senior registrars. It is a dreadful indictment of the present system. I think the Commission could read it with considerable advantage.

2970. We will take it into consideration.—It is a more recent report than our memorandum.

2971. In this particular paragraph you suggest a considerable increase in the ceiling of the Senior Assistant Physician compared with the present ceiling of the senior registrar, as a means of helping to improve his status as well as, I think, enabling him to be established and become permanent. You still do not do what has been suggested in some quarters, that is to provide an overlap into the consultant scale. That is to say it has been suggested that somebody who remained for a very long time, or even permanently, as a Senior Assistant Physician, might well at the end be earning rather more than the young consultant physician taking on a new appointment. Would you think that is worth consideration, to allow some overlap in the salary—since each of the scales are spread over quite a number of years?—Yes, I think that is fair. Of course, at present, a man moves up on promotion from the post of full-time senior registrar. Now it often happens, and it has happened to my knowledge, that such a man has been appointed consultant at a low number of sessions, six or thereabouts; and it may be as such he then receives a consultant salary less than he received as a full-time senior registrar of four or five years standing.

2972. Are you contemplating the Senior Assistant Physician might also be able to be part-time?—We would like to see a number of these men part-time, because that gives them the opportunity of sliding into general practice if they still wish. One of our suggestions is that in the periphery, in which we advocate a reduction in senior registrars and registrars, the younger practitioners actually in practice might come into a hospital on a sessional basis for an hour or two, for two, three or four days a week. That would help to bridge the

gap between the hospitals and general practice. The practitioners would have the opportunity of working in the hospital, in the field in which registrars or senior registrars work under the supervision of the consultant. We believe that that would be to the advantage of the hospital, and likewise to the advantage of the general practitioner. It would bring a levelling up in practice, and it would co-ordinate the hospital work with the practitioners' work in a way which has been neglected at the present time. We would like to have more co-operation with the best doctors in general practice.

2973. Would these opportunities be in some way similar to what sometimes happens now, where general practitioners take on family work and also work as industrial medical officers or school medical officers part-time?—Yes, I think that is a very fair comparison. I think it is something that wants to be encouraged. The practitioner could be used as registrar or senior registrar in a non-teaching hospital. We would like to feel that there is an opportunity of bringing the best doctors in general practice into closer contact with the hospital service. It would be of mutual advantage, and it would enable at the same time a reduction to be made in the registrar establishment. I am sure that is something that requires to be very carefully considered if in 15, 20 or 30 years' time the hospital service is not to run into increasing difficulties.

2974. *Sir Hugh Watson*: We took paragraph 129 rather out of its context because it tied up with what we were talking about; so now we have to go back again. There are some paragraphs in which you deal with some matters which are quite important, but on which we have had a good deal of evidence already; so unless you want to say anything in particular about them I would not propose to touch on any of them now. In paragraph 66 you refer to the S.H.M.O. grade. I think we know about that; it is very comparable to what we have been talking about.—Yes.

2975. To move on, have you any idea what is the extent of private consultant practice relative to National Health Service practice?—I think perhaps Dr. Slater could speak on that.—*Dr. Slater*: Our College are quite convinced that in

the last ten years private consulting practice in medicine has slowly lessened. We can offer many explanations for that having happened, one of which is the mounting number of the general public willing to go and take advantage of the facilities of a well-equipped hospital, which they did not do before the war. Another reason is probably that part-time physicians, who form the bulk of the staff on the medical side, as they do on the surgical side, are performing more hours of hospital work than they used to—there is no question about that in my own mind. A third reason is that places in the periphery like the Borders, Dumfries, Berwick, Fife, have all opened up their own centres of consulting opinion and second opinion and so forth, for the local doctors' advantage and the advantage of the patients in that vicinity, so there is not the same need to come to a teaching hospital as there used to be. A further reason is that modern transport brings the patients so readily to the second opinion with a greater degree of comfort than used to exist. There are many reasons of that sort, but we are all perfectly convinced that private consulting practice in medicine has been and is slowly lessening in volume. As against that, you have to appreciate that there are still people of very special knowledge who will be in demand by many doctors in the country who are aware of the knowledge and the help they may expect from such a person; and there are still a sufficient number in the community willing to meet the expense and defray the costs of having consultations in that manner. But these only happen to be people of very special type here and there where a difficult diagnosis is involved. The fact of the matter is that a patient who is seriously ill will be recognised by his own doctor as requiring the facilities of hospital either for treatment or diagnosis, and he will immediately make arrangements. You find that working out in another respect. When a choice of consultants does not happen to be available it does not mean that the patient suffers. The consultant may not be able to go because of other commitments, and yet some alternative arrangement is agreed upon. Is this answering your question?

2976. Yes; you do attach considerable importance to private practice?—It is an ever-lessening amount, there is no doubt whatever about that.

2977. You feel that private practice is a valuable thing?—It is a very valuable thing indeed. I was thinking of it entirely from the other standpoint, apart from the remunerative standpoint. It is a most valuable thing that the part-time consultant should retain as much contact as he can with private practice, because it lets him mix with a different type of individual, probably on the whole more intelligent members of the community than usually are found in hospital. It enables him to spend a longer time with the individual, he can give greater attention to his history and physical examination; he discusses it with the practitioner in a personal manner, and then he brings all that additional information into his hospital work, to the advantage of the hospital service. We are all convinced about that.

2978. There are other elements of private practice which are still open. Some doctors are employed by insurance companies, and some by firms in industry, and there are various other avenues of private practice still open to the physician?—Yes.

2979. *Mr. Watson*: Would you not say that the difference between the people who stay away from hospital and those who go to hospital is not one of intelligence but rather one of income?—Yes, very largely. I did not mean to infer that only the unintelligent went to hospital, but simply that the more leisured classes might produce some different slant on things.

2980. *Professor Jewkes*: The suggestion was made this morning that one reason why there was a decline in private practice of consultants was that there were frequently no pay beds in the hospitals in Scotland?—That is very true indeed. We on the staff of the Royal Infirmary of Edinburgh feel very aggrieved on that point. We are among the last in the whole country on that. At the same time nursing home accommodation has lessened, in fact it has almost entirely gone out of existence in many instances; and in a city like this it is very difficult to build up a private practice, just for these very reasons.

2981. *Sir Hugh Watson*: One of the points to which the Commission attach considerable importance is merit awards. In your memorandum you say the College believes that in general the

method of allocation of merit awards in Scotland is fair, and that great care is taken to ensure that no injustice is done. Criticism has been made of the secrecy; what is your view about that?—Our College is entirely in favour of the continuation of the merit award system as one very good means of keeping the differentials and holding out a goal of ambition for people coming up to the senior posts.

2982. Do you consider the awards are meant to be enjoyed by a significant minority?—No, I would not allow that; it is more than a significant minority.

2983. That is what Spens said.—I know, but it is not correct! After all, you may take it that the life's work of a consultant is probably 30 or 40 years. So that although there may at any given time only be a small proportion of the total number receiving this additional award, over the 30 or 40 years of his career surely the consultant may look forward, unless he is an unfortunate man, to holding for some period, some form of merit award. From first to last, if a fellow is lucky enough to do the whole run, he is pretty certain to get a merit award.

2984. When Spens talked about a minority, he was talking about A awards only. Some of your colleagues have talked to us of the glittering peaks which are not contemplated by Spens.—We would be entirely in favour of that too, as an inducement.

2985. Have you anything to say on the question of secrecy, Dr. Slater?—We are entirely in favour of this matter of the award not being publicised. There is no point in publishing it. We have got a good trust in the system adopted so far. Every now and then we see somebody with a chip on his shoulder about it, but broad and long we recognise it for what it is, a differential.

2986. In paragraphs 119 and 120 you suggest certain steps which ought to be taken to improve the system. You consider the Regional members of the Scottish Selection Committee should discuss with individual consultants holding grade A merit awards the suitability of candidates to fill vacancies. And you also consider the Department should circularise all consultants.—That is done in practice.

2987. Similarly, the discussions which you contemplate in paragraph 119 do take place, at least in the West of Scotland?—Yes, they do, everywhere.

2988. So that your desiderata are already really fulfilled?—They are.

2989. Is it the belief of the Royal College that all those who might reasonably be considered to feel themselves entitled to receive a merit award feel that they have been considered?—I think undoubtedly; it is their own fault if they have not.

2990. *Chairman*: It has been also suggested that London has more than its proportion of merit awards.—I was not aware of that fact at all.

2991. *Sir Hugh Watson*: At the present time, as you know, these awards are attached to the person.—Undoubtedly; you could not have them attached to the establishment.

Sir Hugh Watson: Thank you, you have anticipated my question.

2992. *Professor Jewkes*: What is the reason for that?—It would make for a levelling down. It would make for mediocrity. A man would know when he reached a certain age he was going to step into a merit award. Further, the other side of the story, it is the one aspect of payment left in the hands of doctors.

2993. *Sir Hugh Watson*: What was suggested to us from certain quarters was that these merit awards should attach to the post rather than to the person?—The College does not hold with that at all, and never has; we much prefer it as it is.

2994. *Sir David Hughes Parry*: You would not like to attach it to a certain amount of seniority?—No, we would rather see something done about pensions for the senior people, quite frankly.

2995. You define a consultant as a man of experience; it could be argued that the longer the experience the better the consultant?—That is true, but he is being rewarded in another way. We would rather see something for the people who came into the Health Service late in life and who must retire in ten or less years—we would rather see some provision made for their benefit in the way of pension.

2996. *Sir Hugh Watson*: That matter has been raised by others and I under-

stand it has not been taken up with the Department.—Speaking for the College generally, I think we would like to see that. It is a distinct hardship when a man comes into the Health Service and can only look forward to serving fifteen at most years before retirement; on the basis of 15/80ths he gets a mere pittance of a pension after he has done what, after all, is equivalent to what the younger people are called upon to do in the Health Service. Dr. Gilchrist has done the same work all the way through, which has only changed in type since 1948.

2997. *Sir David Hughes Parry*: The same problem applies to University people who come in late.—I realise that.

2998. And nothing has been done so far.—One is always hopeful that something will be done.—*Dr. Gilchrist*: If I might butt in. If you take a man, for instance, aged 48 in 1948, that man will retire in 1965, having had 17 years' service. His pension will be calculated on those 17 years. In actual fact that man has probably given 17 years' service previous to the Act; but these 17 years are not taken into account for pension, and if there were some adjustment made for these 17 pre-Service years, I think there would be a greater tendency for the man in this age group in the higher consultant level to be tempted to retire, thereby facilitating the promotion of the younger man. So once again that would help in a little way to solve the senior registrar problem. I would like to put that thought to the Commission.

2999. *Chairman*: That being perhaps the way things happen in partnership, in general practice?—Yes, I believe that is so; but there are a lot of these people who might be eligible to retire in the course of four, five or six years, or thereabouts, and who are not doing so, for the reason that the pensions are so inadequate.

3000. *Mr. Watson*: If that was accepted would you agree that compulsory retirement should be the order of the day?—No, I am not in favour of compulsion in the National Health Service. I do not think men should be forced to retire. I think 65 is a very suitable time, a very reasonable retiring age.

3001. *Sir Hugh Watson*: You would be in favour of compulsory retirement

at 65? Mr. Watson's question was, assuming an appropriate back service credit was given to the doctors of whom you are speaking, would you then be in favour of compulsory retirement at the age of 65?—Yes, I would.

3002. *Chairman*: Without the option of remaining?—65 is the retirement age in the service, in the hospital service at the present time.

3003. There are provisions, I think, to go on to 70—at least I think there are in England.—*Dr. Slater*: Only for people with very special capabilities.

3004. That may in itself be important.—And where no replacement is available.—*Dr. Gilchrist*: I think that is the answer, where there is no replacement.

3005. You would still wish to keep that?—That might have to be kept, certainly. I think you would be bound to have occasional exceptions, but I think the general rule ought to be as at present, that the consultant retires at 65 from the hospital.

3006. *Sir Hugh Watson*: I do not think there is much in this point. In paragraph 123 you refer to the question of the merit award system as applied in Scotland to chosen consultant members of the university staffs. I understand all members of university staffs who have honorary contacts with Regional Hospital Boards which involve work connected with diagnosis and treatment of individual patients are eligible for awards on the same basis as consultants paid by the Regional Hospital Boards?—Yes, and we certainly approve of that.

3007. *Professor Jewkes*: Would you comment on a difficulty which might arise if, through an increase in the earnings of outside consultants associated with an increase in the earnings of medical professors, other groups in the university might feel that they had a grievance?—We have had no adverse comment put to us in the College.—*Dr. Card*: I am a full time member of the university staff, paid by the university. In fact, I am one of those who work the whole of my time in hospital. There is a certain amount of feeling here, which is partly misconceived. I do not think they realise that one is really in effect a hospital doctor and the university is just one aspect of one's work. I understand the suggestion was that they would be partly paid by the university and partly

by the Regional Board in respect of hospital work. I think this is rather an apparent anomaly.

3008. You think there is something to be said for an arrangement that although you should remain a professor at university, part of the payment for your work might well come from the National Health Service?—I should have thought that would be an obvious and fair way to do it; that the hospital work should be paid by the Hospital Board and the university work paid by the university. This was originally suggested, but for some reason never accepted.

3009. I think the universities are not prepared to accept that scheme.—Then I think the universities have only themselves to blame if there is feeling between the medical staff and others.

3010. *Sir Hugh Watson*: We have dealt fairly exhaustively with the present situation. I think I should tell you the Commission are fairly familiar with the advantages and disadvantages respectively of whole-time and part-time consultants. We have been over that ground with several hodies already. Then we come to the future, with which you deal in paragraphs 22 and 23. You suggest the establishment of a small permanent committee on the lines recommended by the Priestley Commission to advise, and to keep under review, the remuneration of the medical profession. Do you have in view that what was set up under the recommendation of the Priestley Commission is advisable?—*Dr. Gilchrist*: Yes.

3011. You would think such a body would be adequate to deal with the situation?—We would think so, Sir. I do not know how successful the Priestley Commission has been. I have no detailed knowledge of that. We did feel there was room for such a body to make definite recommendations of this nature, and I think that is well worthy of recognition. It would serve the interests of the profession, we feel, and the interests of the Government, and I believe also the interests of the country. We have no wish, I can assure you, to have to present a claim for another review in five or ten years' time. We would like to feel that this was a matter on which this Royal Commission would make a recommendation for us.

3012. You would envisage the setting up of a body of neutral persons of such standing that their opinion on these matters would almost compel attention from both sides?—That is my thought. I am looking for the paragraph in which we suggested the personnel of such a committee.

3013. *Chairman*: It is paragraph 133.—What we felt was that there should be such a committee, with membership consisting of probably a Law Lord, leaders of industry, people of public standing, whom the profession, the Government and the public would trust.

3014. *Chairman*: This, I take it, would be to deal with major matters. But the detailed matters which are constantly arising you would expect to be continued to be dealt with on a more direct basis between the Ministry and the profession.—Yes, I am sure that is true. I think it is fair to say it has given a great deal of embarrassment to many people in the profession to have these recurring interviews with Whitley Councils, Ministers of Health, and so on. For myself, I am sure I speak for the College when I say that we do not like to be the shuttlecock of political parties, or at the whim or personal prejudices of successive Ministers of Health. We would like to feel that these matters were in the hands of responsible and independent bodies.

3015. *Professor Jewkes*: Of course, Doctor, you would not have to expect too much from this, would you? When one speaks of a neutral body one naturally thinks of a body which will be much more sympathetic towards one's own views than anybody else's. It might happen that the suggestions of a neutral body were challenged by one side or another; then its prestige might be destroyed. It is not a foolproof method.—I certainly agree to that. We recognise the human frailties on both sides of the table.

3016. *Sir Hugh Watson*: I think the only other thing I would like to do is to thank you for the cordial sentiments expressed in paragraph 24.—Thank you very much indeed. I would like to say that we are very much indebted to the Commission and are very glad to have had this opportunity of putting our views before you.

Chairman: Professor Jewkes has one point I think and I have one or two more.

3017. *Professor Jewkes*: A small question arises out of something that was said this morning when the Surgeons were before us. When they were discussing the extent of private practice they mentioned of course the decline of pay beds, mainly through the disappearance of nursing homes. They then went on to explain there has been very little new building of hospitals, certainly in Scotland, since the end of war, and they rather deplored that. I wondered whether the Physicians would say the same thing is true. Has there been a shortage of new building and extensions and so on since 1945 which alarms you?

—Yes, most decidedly. It is very regrettable that our teaching hospitals here have no private wards. There is no accommodation in, say, the Royal Infirmary here, on the medical side of the hospital or on the surgical side—with one exception neuro-surgery—where the patient who is willing to pay can pay.

3018. *Chairman*: That was also the case before 1948?—That was the case before the service and it persists to this day. We feel it is a very sad deficiency.

3019. *Sir Hugh Watson*: May I remind you that since the introduction of the service 11 nursing homes in Edinburgh have closed down?—That is true.—*Dr. Slater*: The result is patients are being admitted to the Royal Infirmary, who would in ordinary circumstances be quite prepared to pay. There are no facilities to allow patients who are able to pay to do so.

3020. *Chairman*: We heard this morning from the Surgeons that they considered it might be advisable to restrict part-time service to appointments involving a minimum of nine sessions. I take it with your general plan of more flexibility—registrars doing work outside and general practitioners inside—it would be quite contrary to what you would wish. You would expect people to be allowed to do quite a small number of sessions, not merely nine or upwards?—*Dr. Gilchrist*: I think it is difficult to be too rigid in our views about that. I think a great deal depends on a man's individual inclination, and I think that applies also to the consultant. I think there are consultants who would very much like to be doing nine sessions who at present are doing perhaps six or seven. I think there are probably others who might welcome a reduction of the sessions. I think we

want to be a little more fluid than we are, not merely amongst consultants but registrars as well.

3021. You want more fluidity, not less?—Yes, definitely more fluidity. I think this has been put to us: we are tending to be much too rigid; we tend to conform far too much. I do not know whether it is just the natural inclination of the administration, but the Regional Boards ought to give a little more latitude. I think the hospital requires more latitude. Individuals serving the hospitals should be given a little more latitude. We must not keep the hospital service on such rigid lines. I would like more fluidity throughout the hospital. The College and the people who have experience of the Act and its working would support that view.

3022. Then the other point I wanted to ask was one you may not feel able to answer. This question has arisen as to how best merit among general practitioners can be rewarded. Have you any suggestion at all about that?—That is a difficult question to answer. I think probably I should just say there is a justification for considering a merit award for general practitioners. As to just how best the man should be chosen for the award I find it a little difficult to answer. Would you like to answer, Dr. Slater?—Dr. Slater: Of course, we have not dealt with this in our memorandum at all. I sympathise with the idea of giving general practitioners a reward for distinguished service if you like to put it that way. I cannot think of a better method of doing it than to ask the practitioners in a given area—say the South East Regional Board area—in the form of a poll who should get it. I feel certain that from that poll you would get the most outstanding people in the district who do give long and faithful service in their district. And the younger men in that community would realise immediately their chance would come along in due course and they would not feel any jealousy at all.

3023. Sir Hugh Watson: Would you attach importance to the sort of facilities that the general practitioner provides in the way of receptionists, physiotherapists, consulting rooms and that sort of thing?—Dr. Slater: I would leave it to his fellows, to his peers, to judge him. I do not think they would go far wrong.

3024. Mr. Bonham-Carter: May I raise a question on a point which I think came up a little unexpectedly on pensions? We began to talk of what I would call "back service", service before the Act. Of course this is a contributory scheme, is it not, this superannuation scheme for the profession based on a 6 per cent. contribution?—Dr. Gilchrist: I think that is true.

3025. How would you deal with the "back service" section of it? The fund is short in respect of all those years for which people have not contributed?—Yes. I appreciate that point. Of course I do not imagine that the man's contribution over these years in actual fact covers the pension. I suppose this is a question for an actuary. I am not an actuary. I imagine there are actuaries here. I imagine the contribution which that man makes does not in fact total up to the amount of pension which he receives. Am I wrong in that?

3026. Mr. Gunlake: It depends on a number of things including his age.—Including his age and his years of service.

3027. Mr. Bonham-Carter: I am sure it is an actuarial problem as you mention. Inevitably when this situation arises there is this question of a back payment. It occurs quite frequently. But what one normally does on those occasions is to ask the contributor if he wishes to contribute any savings which he may have acquired prior to the date he came into the scheme.—I think in the circumstances we are considering, where a man has a limited number of years service and comes into the scheme having given previous service, there are many who would willingly contribute at a greater rate before they retire. I am sure it is a problem that could be adjusted with advantage so that you did encourage earlier retiral amongst a certain group.

3028. It certainly could be done. It might involve considerable capital expenditure by one or the other party.—I think as I say many might be prepared to contribute at a higher rate.

3029. Chairman: I think that is the end. Thank you Dr. Gilchrist. I would like to thank you and your colleagues very much for coming and giving us your help this afternoon.—Thank you very much for the way you have received us, Sir.

(The witnesses withdrew.)

ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

Supplementary Statement presented by Dr. A. Rae Glichrst on the
New Structure of Hospital Grading and Salaries proposed by the
Royal College of Physicians of Edinburgh

In amplification of the evidence already submitted to the Royal Commission by the Royal College of Physicians of Edinburgh, I wish to emphasise two points to which I think insufficient attention was devoted at the hearing of our oral evidence on Friday, 14th March. As President of the Royal College of Physicians, I think I should have explained more effectively when tendering our evidence that we are desirous of modifying the second recommendation expressed on page 547, paragraph 89, of our memorandum of evidence.

That recommendation reads: "(2) The posts at present designated Senior Registrar and Registrar, but replaced by the new terms, should in general medicine, surgery and obstetrics be confined to teaching hospitals." On reflection, my Committee feel that, while the Senior Registrar and Registrar posts should be retained in teaching hospitals, the Senior Registrar establishment should be abolished in the peripheral non-teaching hospitals. We do not now recommend that the Registrar appointments should be entirely abolished in the peripheral hospitals, but we feel that some reduction in the number of Registrars employed in the peripheral non-teaching hospitals would be justified. A reduction in their numbers would enable a start to be made with the employment of selected general practitioners in the non-teaching hospitals on a Registrar basis.

The second point is that, from memory, I doubt if sufficient emphasis was put in our oral evidence on the undesirability of having a so-called "sub-consultant grade" in the hospital service. The Royal College of Physicians does not support such a proposal.

In advocating a new structure of hospital grading, the College has been influenced by a number of considerations:—

(1) *The standards of medical care and attention in the National Health Service are likely to suffer if the current "bottle-neck" in the promotion of Registrars is allowed to persist.*

(a) In Scotland there is already definite evidence of a lack of fresh recruits at Registrar level for the reason that the prospects of promotion for the existing Registrars are so poor. For example, the number of our own graduates applying for Registrar appointments in the Royal Infirmary and other teaching hospitals in Edinburgh has decreased considerably in recent years. Men from the Commonwealth are now tending to occupy many Registrar posts in the various hospitals, including the great teaching hospitals, in this country. They do so commonly for a year or two before returning to New Zealand, Australia, Pakistan or India. They give excellent service but their training in the Registrar appointment in the hospitals of this country is at the expense of the British taxpayer and is not necessarily to the ultimate good of the National Health Service. As fewer of our own men apply for these Registrar posts, the choice of Senior Registrars, the Consultants of the future, becomes more and more restricted. This is bound in the long run to have a detrimental effect on the standards of medical care and attention available in the hospitals of this country in the future.

(b) For similar reasons the proportion of graduates entering general practice, having a two-year Registrar experience, must also fall. It would therefore appear probable that the proportion of men entering general practice with a hospital experience greater than the average will show a progressive tendency to decrease if the Registrar "bottle-neck" is not relieved.

(2) In our opinion it is imperative to improve the prospects for the advancement of the existing Senior Registrars.

The "bottle-neck" in Registrar appointments has to date appeared an insoluble problem. Endless negotiations have been in progress for the last four or five years and numerous interviews have taken place between the Ministry of Health and representatives of the profession, without material benefit.

There are, for instance, 43 medical Senior Registrars on the establishment in Scotland at the present time and 12 possible Consultant vacancies in the next five years. The disproportion between these two hospital grades applies not merely to general medicine but to all branches. We understand that there are, for instance, at present in Scotland 250 Senior Registrars and 897 Consultants employed in the hospital service. I wish to direct the attention of the Royal Commission to the article which appeared recently in the *British Medical Journal* (December 14, 1957, p. 1426) entitled "Promotion Prospects for Senior Registrars in Scotland" by Dr. Hamish Watson.

To rectify this situation, we believe that the number of Consultant posts in general medicine, surgery and obstetrics in the peripheral hospitals should be increased. At the same time we believe that the Senior Registrar appointments in the periphery should be abolished and the Registrar appointments in the periphery considerably reduced in numbers. By replacing the Senior Registrar establishment in the non-teaching hospitals by Consultants, a great reduction in the "bottle-neck" could be achieved at one stroke. In Scotland there is ample room for more Consultants in the periphery, many of the existing Consultants being grossly overworked. In our view, Senior Registrars in the three major subjects—general medicine, surgery and obstetrics—should be confined to the teaching hospitals.

The abolition of the Senior Registrar appointments and the reduction of the Registrar appointments in the non-teaching hospitals would have certain consequences:—

(a) A possible saving of money to the Regional Boards, counterbalanced to some extent by the burden of additional Consultants in the periphery.

(b) A greater responsibility might be imposed on the Junior hospital staff, so much so that we feel that as far as possible the most junior ranks in the hospital service should be strengthened by the employment of Senior House Officers in the non-teaching hospitals, that is, one who has already had a year's experience as a House Officer. To do this successfully implies that the post of Senior House Officer at present available in certain charges of the teaching hospitals should be abolished and made only available in the non-teaching hospitals. Thus, the junior staff in the peripheral hospitals would as far as possible be more experienced, hence compensating to some extent for the reduction which we propose in the Registrar establishment.

(c) The re-distribution of the Senior Registrar and Registrar posts would result in an increased responsibility for the Consultants in the periphery. The absence of Senior Registrars and the reduction in the Registrar establishment implies that more of the investigative work in the wards would lie in the actual hands of the Consultant. He would have more to do but this would be compensated for by an increase in the Consultant establishment in the non-teaching hospitals, thus easing the burden and allowing for some interchange of duty for night work and hospital emergencies.

(d) An important consequence of the abolition of Senior Registrars in the non-teaching hospitals is a widening of the scope for employment of local general practitioners in the hospital service at a Registrar level. It is our view that in the non-teaching hospitals many men engaged in family practice could give valuable service in the routine investigation of in-patients and in the supervision of hospital out-patients. These practitioners might be employed on a sessional basis for two or three days per week and work, as the present Registrar works, under the supervision and direction of the Consultant. We consider that a liaison of this kind would be to the mutual advantage of the general practitioner and of the Consultant in the peripheral hospitals. In the long run it would tend to improve

the standards of care of the patient in general practice, it would widen the practitioner's interest and it would promote a closer contact between the hospital and family practice. A sharing of experience on this basis would be of mutual advantage.

In addition, we recommend to the Royal Commission a consideration of the suggestion that such Registrars as are attached to peripheral hospitals could with advantage widen their experience by part-time duty in general practice. We believe that this interchange between the hospital service and the family doctor would do much to break down the barriers which exist at present and would in the long run be of mutual advantage to both.

(3) *To give such Senior Registrars as remain in the service a greater sense of security.*

If Senior Registrar appointments are confined to teaching hospitals, as we recommend, their total numbers would in future bear a much closer relationship to the number of possible Consultant vacancies. It is desirable that the Senior Registrar, having completed his four years of training, should be retained in the service with an adequate salary and yearly increments for, say seven years. Thereafter these "time expired" Registrars should remain in the hospital service either permanently in that grade, or until such time as they obtain a consultant vacancy. This would do much to dispel their sense of insecurity and at the same time retain adequately trained men for the benefit of the hospital service.

(4) *We wish to emphasise that these recommendations are not necessarily intended to apply to the hospital service in England.*

Conditions of practice, general and hospital, are different in the two countries. This has already been recognised in the N.H.S., one Act applying to England and the other Act, with its special provisions, to Scotland. The hospital service in the areas of dense population, notably in the Midlands of England and elsewhere, is based to a much less extent on the teaching hospitals than in Scotland. To deprive the English non-teaching hospital of its staff of medical, surgical and obstetrical Registrars might well prove an embarrassment and be detrimental to the service in these localities as a whole. Our recommendations are designed for Scottish conditions with which we are all fully familiar.

In advocating the retention of Senior Registrars and Registrars in the Scottish teaching hospitals, we also believe that a change of name is desirable. The terms "Senior Registrar" and "Registrar" are foreign to Scottish medicine. They were not in use previous to 1948. We believe that these posts should be designated "Senior Assistant Physician" (Senior Registrar), "Junior Assistant Physician" (Registrar), and in addition the House Officer would be better known as "House Physician" or "House Surgeon", as the case may be. Our advocacy of this change of title has caused some confusion. To judge from the oral evidence of the Joint Consultants Committee given on Wednesday, 18th December, 1957, it would appear that some of the members of the Royal Commission, and indeed, some of the representatives of the Joint Consultants Committee, did not appreciate that our College is *not* proposing a sub-consultant grade in the hospital service. That point cannot be too strongly emphasised. We are making what we believe to be valuable positive suggestions for the correction of the Registrar and Senior Registrar problem as it affects Scotland and we consider that the recommendations now put before the Commission will go a long way to right a defect in the service which is likely to grow worse with time and which is detrimental to the hospital service as a whole.

A. RAE GILCHRIST,

*President,
Royal College of Physicians,
Edinburgh.*

17th March, 1958.

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MINUTES OF EVIDENCE

12—13

Twelfth Day, Thursday, 20th March, 1958

Thirteenth Day, Friday, 21st March, 1958

WITNESSES

British Dental Association



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TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

TWELFTH AND THIRTEENTH DAYS

Thursday, 20th March, 1958

Friday, 21st March, 1958

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Memorandum to The Royal Commission on the remuneration of
National Health Service Doctors and Dentists

PRESENTED BY THE BRITISH DENTAL ASSOCIATION

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PART I**AUTHORITY OF THE BRITISH DENTAL ASSOCIATION****History and Membership**

1. The British Dental Association was founded in 1880, in which year the membership list contained 252 names. By the time of the Association's Jubilee in 1930 it exceeded 4,000, and by 1949 it had risen to 7,700. In November 1949

the Association amalgamated with the Incorporated Dental Society and the Public Dental Service Association and the current membership is 11,000. The Dentists Register contains the names of 16,000 dentists, of whom only about 13,000 are in active practice. The bulk of these practising dentists are members of the Association, as out of the total membership of 11,000 only some 300 or 400 are not still actively following their profession.

2. The Association's membership is open to all registered dentists after election by the Council of the Association, on the recommendation of three existing members. It includes the great majority of dentists providing general dental services under the National Health Service and dentists practising on their own account outside the Health Service; health centre dental officers; hospital dental officers; local authority dental officers; dental officers in the Armed Forces; and university professors and teachers of dentistry.

3. It is also relevant that the Association's largest Standing Committee (the General Dental Services Committee), which has a membership of 70, is elected in a manner which does not apply to any other of the Association's Committees. The General Dental Services Committee's functions, as laid down in the Association's Articles, are "to deal with all matters affecting members of the profession in their capacity as practitioners providing general dental services under the National Health Service Acts and any Act amending or consolidating the same, and to watch the interests of practitioners in relation to these Acts." Six members of the General Dental Services Committee are elected by the Conference of Local Dental Committees which takes place annually, and of the remainder half are elected by individual Local Dental Committees or groups of Committees and half by the Association's Representative Board. Local Dental Committees, it should be explained, are bodies set up under the National Health Service Acts primarily for the purpose of helping Executive Councils to discharge their responsibilities under the Acts, and are not part of the British Dental Association machinery. Membership of the Association is not a requirement of membership of a Local Dental Committee and it is, therefore, possible for non-members of the Association to serve on the General Dental Services Committee, although as has been explained the vast majority of practising dentists are in fact Association members.

Objects and Activities

4. The main objects for which the Association was established in 1880 were "the promotion of the dental and allied sciences and the maintenance of the honour and interests of the dental profession." Those objects still constitute the Association's chief "raison d'être," and are fulfilled in many ways. Through the Association's Annual Conference, the *British Dental Journal* and the Library, and not least through frequent meetings of the Association's Branches and Sections, there is made available to members a fund of knowledge valued by all who are anxious that their professional learning and skill should continue to develop after they pass out of dental school. Furthermore, constant interchange of knowledge takes place between the Association and similar bodies in the Commonwealth and other countries, both by direct contact and through the medium of the International Dental Federation.

5. The Association are justifiably proud of their record in the promotion of dental health. Those who were the founder members of the Association also played leading roles in the events leading up to the passing of the Dentists Act 1878, whereby dentistry first took its place amongst the learned professions. Since then, their successors have been responsible, *inter alia*, for dental work during the South African war which laid the foundation of the Armed Forces Dental Services as they exist today, and for activity within and outside the Association in the field of child dental health which led to the creation of the Local Authority dental services, and, in 1954, to the publication by the Association of a memorandum which received considerable and very favourable publicity and which had a circulation in Great Britain, the Commonwealth and elsewhere, of close on 3,000 copies. The Association's continuing interest in dental health is evidenced by the fact that one of their most active Committees is the Dental Health Committee which has Sub-Committees on Dental Health Education, Child Dental Health, and Dental Research.

6. The honour of the profession has been jealously safe-guarded by the Association. During the period 1880 to 1921 the Association established and maintained a code of professional conduct for their members, including the prohibition of advertising of all descriptions and of canvassing for patients. On the setting up, under the Dentists Act 1921, of the Dental Board of the United Kingdom, this code of conduct became obligatory on the entire profession and remains so today, but it is now administered by the General Dental Council (which superseded the Dental Board in 1956). The Association still concern themselves with matters of professional etiquette, so far as their members are concerned, through their Membership and Ethics Committee.

7. Much has happened, of course, during the 77 years since the Association came into being, and ever since the introduction of the National Health Service the activities of the Association have really been in two broad divisions. The first of these, the academic and scientific, has already been dealt with in some detail; the second may be called "the political," on which side the Association provide all dentists with a service which is essential to their professional life. There are few practitioners today who do not spend some part of their lives working for the State, whether in the general dental services, in the hospital service, or in the employment of local authorities. The pay and conditions of service in every one of these branches of the Health Service are determined by negotiation between the appropriate Ministry or representatives of local authorities on the one hand and the British Dental Association on the other. There is no other dental organisation in the country which is able to perform this function for the profession or has a mandate to do so. Protection against inroads upon the professional freedom of dental practitioners, upon their standards of living and upon their conditions of service is secured only as a result of the efforts of the British Dental Association. It may perhaps be pertinent to add that earlier description of the second main activity of the Association as political is by no means inappropriate because such activity has indeed been necessitated to a very large extent by the steady encroachment of politics upon dentistry during the last decade, and this is a matter of regret to all.

8. It is hoped from what has been said above that the Association have made it abundantly clear that **they alone have a title to represent and speak for the profession at large** and not simply for members of the dental profession engaged in a particular sphere of activity, such as the National Health Service.

PART II

THE NATURE OF DENTISTRY

The Attitude of the Public

9. In their Memorandum to the McNair Committee, the Association included a section which outlined what was considered to be the attitude of the public towards dentistry, and as a preliminary it is thought appropriate to quote paragraph 17 of that Memorandum:

"*Para 17—Ignorance as to the Nature of Dentistry.* Until the second decade of the present century, the general impression held by the public was that the dentist was a man whose chief occupation was 'pulling teeth' and the Association are convinced that even nowadays most people have no idea of the nature and scope of the work which a dentist performs. Old notions die hard and it must be remembered that only a generation ago advertisements of 'painless extractions' were common, not only in newspapers but also on house and shop fronts: furthermore, within living memory demonstrations of 'painless dentistry' were given in market squares by itinerant 'dentists' with an accompanying band to submerge the effects of their activities. It is not surprising that past generations of the public were almost completely ignorant of any other aspect of dentistry and there is no doubt that their memories and recollections have been passed on to their children and grandchildren. These old stories bear no relationship whatever to modern dentistry but it is likely to be many years before the unfortunate effects of these tales are entirely eradicated from the public mind."

10. What is said in the quoted paragraph scarcely needs embellishment but it is also desirable to make passing reference to what is said in paragraph 18 of the Memorandum to the McNair Committee. It is there pointed out that because of general ignorance regarding dentistry many children are taken to the dentist only when they are in pain and that in consequence they associate dentistry with an unpleasant experience. Attention is also drawn to the fact that memories of school clinics or private surgeries which were dismal and depressing must likewise have a subconscious effect on the attitude towards dentistry of some members of the public. Finally, mention is made of psychological reasons for public antipathy towards dentistry the pursuit of which profession, as will be shown, calls for the possession of mental and physical attributes of the highest quality.

11. Nothing can be farther from the truth than the impression that the chief occupation of a dentist is the extraction of teeth. It is certainly true that, until public enlightenment as to the value of oral health has grown immeasurably, there is likely to be such a lack of dental care as to make it inevitable that many members of the profession will be called upon to relieve pain and prevent the spread of decay by the removal of carious teeth, but the Report of the Ministry of Health for 1955 makes it clear that there has been a steady increase in the amount of conservative treatment under the National Health Service in recent years. This circumstance is doubly encouraging from the profession's viewpoint in that it gives ground for their hoping to exercise to an even greater extent the manipulative skill, artistic expression, and scientific application in the prevention of dental disease which they acquired during their lengthy and expensive period of training, and it also indicates a definite though gradual inculcation in the public mind of dental health principles.

The Scope of Dentistry

12. The many facets of dentistry can scarcely be appreciated by those who are not associated in some way with the profession and it may be helpful to recapitulate the remarks contained in paragraph 45 of the Association's Memorandum to the McNair Committee, the purpose of which was to endeavour to remove false impressions regarding limitation of scope:

"Para. 45—The development of consultant and specialist services is a feature of modern dentistry and the whole profession plays an important role in safeguarding the health of the people. Dentistry embraces diagnosis of disease of the teeth, gums, mouth and surrounding tissues and the recognition of oral manifestations of general disease. Radiographs and pathological laboratory reports aid in diagnosis. Orthodontics, which has for its object the prevention and correction of irregularities of the teeth, is the study of growth and development and presents biological problems which are solved in part by the use of mechanical appliances.

Conservative dentistry deals with operations on the teeth to restore æsthetically and biologically their form and function.

Periodontology, the science relating to the supporting tissues of the teeth, is equally important in preserving the teeth and maintaining them in health.

Oral surgery implies operations on the teeth, bones and soft tissues of the mouth and includes extractions and excision of misplaced and deeply buried teeth and cysts. Dentistry has also a prominent part to play in maxillo-facial surgery. Prosthetic dentistry is the science and art of providing substitutes for lost tissues and teeth. It includes the provision of bridges and dentures and of appliances necessary in cases of cleft palate or following major surgical operation on the face and jaws. Æsthetic considerations play an important part from the point of view of the patient and it is often necessary to build dentures which will restore the contours of the face. All this requires an adequate knowledge of the basic sciences and of numerous materials and drugs coupled with a wide experience in the administration of local and general anaesthetics."

Relationship of Dental Health to General Health

13. It will be gathered from what has been said above that the modern dentist, while primarily required to be a skilled surgeon, has also to be a craftsman and

an artist, whose work is of inestimable value in the preservation of oral health and thus the maintenance of general health. This last question was one into which the Teviot Committee went in great detail, their views being set out in para. 65 of their Interim Report. Repetition of all that the Teviot Committee said would be pointless, but the following two sentences are quoted as being of special significance:

"... it suffices to say that dental neglect is responsible directly, or indirectly, by lowering body resistance, for much avoidable suffering and ill-health."

"... A diseased mouth may offer a portal of entry to infection and by preventing response to treatment prolong incapacity."

It may be added that in their own evidence to the Teviot Committee the Association quoted extracts from a memorandum which they had earlier submitted to the Interdepartmental Committee on Social Insurance and Allied Services (the Beveridge Committee) and in further emphasis of the relationship of dental health to general health the largest of those extracts (Para. 5 of the memorandum) is set out below:

"The Departmental Committee on Sickness Benefit Claims stated that 'in a very large group of cases on which benefit was paid no permanent cure was possible until the teeth had been attended to.' One of the largest Approved Societies, the Prudential, stated that 'neglect of teeth troubles was the cause of quite half the ill-health found among the industrial classes, of which a large majority occurred in young women.' The Industrial Federation of Women Workers attributed many claims to the absence of any provision for dental treatment. The experience of Insurance Committees under the National Health Insurance Acts indicated that anaemia, gastric troubles, debility, tonsillitis, neurasthenia and rheumatism were attributable to or aggravated by defective teeth. A Chief Medical Officer to the Board of Education, Sir George Newman, has stated that 'the gravamen of dental affections is its secondary results.' He suggests that 'toxic neurasthenia might result in the child and the adult, joint affections, anaemias, gastric intestinal effects, the more remote skin, eye and nervous conditions. Many cases of adolescent dyspepsia' he considered, 'might be attributed to loss of teeth in childhood.' Loss of manpower to the State due to dental diseases was recognised during the War of 1914-18 and resulted in the creation of the Dental Branches of the Royal Navy, the Army and the Royal Air Force. During the present War those Services have been expanded very greatly."

Value of Dentistry to the Community

14. The McNair Committee also "felt it necessary to ask what contribution dentistry makes to the Nation's health and well-being" because they saw that "if dentistry is an essential, expenditure of man-power and money upon it needs no further justification." The McNair Committee answered their own question with the words "we have no doubt that in a civilised community an effective dental service is an essential... we are completely convinced of the value to the community of good dentistry available to all."

Contribution of Dentistry to the National Economy

15. It is difficult to evaluate exactly the contribution of dentistry to the national economy. Dental disease is the most common affliction from which mankind suffers, and it is clear that the number of man-hours lost to industry, directly or indirectly due to dental disease, would reach an astronomical figure each year were it not for the skill and care of the dental profession in the treatment of their patients. It can therefore justly be stated that a dentist does make a very real contribution towards national productivity inasmuch as he helps to maintain the health and fitness of the working population and of the children as the next generation of workers.

21. The Association's views as to steps which should be taken to alleviate the situation were contained in paragraph 60 of the Memorandum which likewise is now reproduced:

"*Para. 60*—Financial aid available to intending dental students is afforded under the same arrangements as those which govern awards and grants to students generally. The suggestion may be made that benefits open to dental students should be increased, but this idea has been rejected by the Association as being undesirable in principle. It is considered, however, that there should be uniformity in the dispensation of awards and grants by local authorities so that wherever young men and women may happen to live they have equal opportunities of attaining their ambition of training for a profession. It is, of course, implicit in this suggestion that the standard to which all authorities should conform should be that now adopted by the more generous authorities. Furthermore, local authorities should be reminded that the length of training for one profession as compared with that for another should not be a determining factor in deciding whether or not to make an award to a particular student. The Association also take the view that the range of maintenance grants should be extended in order to minimise the possibility of children of parents with comparatively large 'scale incomes' being deprived of the opportunity to train for dentistry because of the heavy financial contributions which their parents would have to make towards the cost of their training and maintenance, which contributions would not rank for tax relief."

The University Grants Committee

22. It is obvious that the Association's views on this question of financial assistance to students had a favourable reception by the McNair Committee because Appendix VII on pages 54 to 59 of the Report of the McNair Committee is devoted entirely to this particular subject and the solution to present difficulties advocated by the McNair Committee is very much in accord with what the Association had to say in their document. There is one further point of some importance which has a bearing on this matter, namely, the advocacy by the McNair Committee in the penultimate paragraph of Appendix VIII of their Report of "a further earmarked grant by the University Grants Committee" in order to "fertilise the young plant and encourage the growth of a somewhat stunted tree." This forthright comment and most apt analogy were clearly prompted by the knowledge that discontinuation by the University Grants Committee of the practice of making to universities a grant earmarked for dental purposes, had produced the situation that admission or rejection of would-be students is being governed even more by the extent and method of utilisation of the financial resources of the Universities than by the ability of the parents of applicants for entry to meet the financial burdens likely to be imposed upon them.

Inability of Dental Students to Earn During Years of Training

23. There is one side issue of dental training which is by no means unimportant. Dentistry is not a career for which study can be undertaken on a spare-time or part-time basis as is possible in the case of other professions, e.g. the legal profession (solicitors), accountancy, engineering, and architecture. Dental students, like medical students, have of necessity to undertake full-time study and the cost thereof is inevitably high. Sufficient reference has already been made to the question of expense and the object of this paragraph is simply to highlight the fact that dental students, unlike their fellows training for some other professions, have to wait until their long period of education has ended and they have passed examinations of a justifiably high standard before they can earn their own living. Furthermore, owing to the nature of their studies they are unable, except in the very early days of training, to take up employment during vacation periods.

Educational Requirements

24. Having dealt in some detail with the financial problems of dental students, it is now appropriate to consider precisely what a student has to face before he can become a dentist: it can be said here that references in this Memorandum to the

male can be taken as applying equally to the female because the Association recognise that dentistry is a very suitable career for women, who in the past have received too little encouragement to train for the profession.

25. It is the Association's aim to demonstrate that in order to become mentally and physically equipped to perform the skilled and responsible work of which examples are given in the preceding Part, educational requirements of a high standard have to be fulfilled initially and a long and costly period of study and training has to be undertaken.

26. Every student seeking admission to the dental curriculum must first have passed:

- (a) A recognised preliminary examination in General Education, equivalent to an Entrance Examination of a University in the British Isles; e.g. the General Certificate of Education at the appropriate standard or some other examination accepted for this purpose by such a university or other licensing corporation;
- (b) An examination or examinations, conducted or recognised by the licensing corporation concerned in the subjects of Physics, Chemistry (physical, inorganic, and organic), and Biology.

There is some variation in the general educational requirements of the dental schools but the basic educational standards for all entrants into the University of London, which are given below, give an excellent idea of what is expected of candidates:

The candidate must have obtained in the General Certificate of Education
EITHER

- (a) a pass in six subjects which include:
 - (i) English language.
 - (ii) A language other than English.
 - (iii) Mathematics or an approved science.

Not less than two of the six subjects must be passed at the advanced level.

The requirements set out here may be fulfilled at more than one sitting of the examination.

OR

- (b) a pass in five subjects which include:
 - (i) English language.
 - (ii) A language other than English.
 - (iii) Mathematics or an approved science.

At least three of the subjects must be passed at the same sitting of the examination, and at least two of these three at the advanced level.

Anyone entering the University of London to study dentistry must, in addition to these basic educational requirements, have obtained passes in the General Certificate of Education, at least at the Ordinary Level, in Chemistry and Physics as separate subjects.

The Dental Curriculum

27. Having successfully cleared this preliminary hurdle and secured admittance to a dental school the student then embarks on a course of study for a licence or degree in dental surgery extending over a period from four and a half years to six years. The time varies according to the particular course taken and is also affected by whether or not the preliminary science subjects (chemistry, physics, botany, biology or zoology) are being taken at the university: exemption from the first year of the course is generally given by universities if a student has successfully taken the preliminary science subjects at advanced level in the General Certificate of Education examination. There is some variation between one university and another; as an example, London University grant exemption from the first year of the

non-participation in the main inquiry. The 'Dentists 1921' have received no recruitment since 1921-1926 and the average age of the numerous survivors who are still in practice must be many years in excess of the average age of the 'licentiates.' That is an adequate explanation of the difference between 18 per cent of the 'Dentists 1921' having pleaded ill-health against only 7 per cent of the 'licentiates.' But the overall rate of 58 out of 505, nearly 12 per cent seems very high, and it supports the opinion, which is generally held in the profession, that the excessive amount of work which dental practitioners are performing in their efforts to cope with the rush of work produced by the introduction of the National Health Service, is taking its toll."

If any statistics relating specifically to dentists had been available it is doubtful whether they would have been of any real value because there is no question but that dentists in general practice have to be very ill indeed before they voluntarily absent themselves from their surgery; the reason for this is simple, viz. the income of a single-handed dental practitioner ceases and the income of a practitioner with assistants or in partnership is reduced immediately he himself stops work, whereas most of his practice overheads and expenses are in no way abated. Further reference to this question is made in paragraphs 44, 92 and 115 of this Memorandum.

Mortality

35. The mortality rate of dentists is another matter and on this subject correspondence has taken place with the Registrar-General. It is understood that his Department are in process of compiling an analysis, according to occupation, of the deaths registered during the five years 1949-53. When the volume is published copies will be obtainable from H.M. Stationery Office in the usual way but as six months at least are likely to elapse before publication takes place the Registrar-General has been asked if an advance extract for the assistance of the Royal Commission and the Association can be provided. The answer unfortunately has been that many requests for advance information have already been received from other organisations and that if these were to be complied with the preparation of the volume as a whole would be seriously interrupted. In the circumstances the Registrar-General has decided against release in advance of general publication of information which will be contained in the analysis.

36. This is singularly unfortunate as it is understood that the volume will contain figures which will enable comparison to be made between the mortality rates of dentists, by ten-year age groups from 25 up to 65, with the mortality rates of any other profession. It will also contain information about causes of death, showing the numbers of deaths confirmed and expected for the age groups 25 to 65 as a whole. In the absence of comparatively up-to-date information, which may of course be available before the Commission finish their deliberations, the Association can only draw attention to the Registrar-General's Decennial Supplement for England and Wales, based on the 1931 Census, Part IIA, Occupational mortality, from Table 6A of which the following information has been abstracted:

RATIO OF DEATH-RATES OF MALE DENTISTS (1930-1932) TO THAT OF ALL MALES TAKEN AS 100 ALL CAUSES

<i>Profession</i>	<i>Age 45 to 55</i>	<i>Age 55 to 65</i>
Dental practitioners	112	101
Medical practitioners	108	111
Judges, barristers and solicitors ...	95	104
Architects	94	92
Professional Engineers	84	97
Accountants	76	98
Teachers	61	75
Higher Civil Servants	59	84
Clergymen	51	76
All professional men	88	95

37. It will be noted that two age groups only have been covered, although, of course, the detailed information in the Decennial Supplement covers younger age groups as well. The reason why the two groups (45-55 and 55-65) have been singled out is that the figures relating to those groups, and in particular to the first group, indicate that dentists have the highest mortality rate amongst professional men at an age when professionally they should be in their prime. It is appreciated, of course, that the statistics are over twenty years out of date but they relate to a period during which the dental health consciousness of the population had yet to be awakened to the extent to which it undoubtedly has since the war and in particular since the inception of the National Health Service.

38. The 1951 Census statistics which are so far available do yield one item of information which is enlightening, viz. that the mortality rates for all professional men in the age groups 45-55 and 55-65 were respectively 98 and 99. These figures show marked increases on those based on the 1931 Census which are given at the foot of the table in paragraph 36. To what causes these increases in the mortality rates for all professional men may be attributed is not known: possibly the higher tempo of life since the Second World War is a major factor. Be that as it may, there is no doubt that since the inception of the National Health Service there have been increased calls upon the time and energy of members of the dental profession, and when regard is had to the arduous nature and the strain of dentistry (see paragraphs 32 and 33) there is every justification for the assumption that the full 1951 mortality statistics which will eventually be published by the Registrar-General, will show that mortality rates for dentists did not merely rise between 1931 and 1951 but indeed increased disproportionately to the mortality rates for all professional men. If, as seems highly probable, the disparity in mortality rates which was already marked in 1931 is shown to have widened, and dentists remain at the top of a table which certainly no profession wishes to head, the conclusion to be drawn from that circumstance is inescapable: the views of the Spens and Teviot Committees as to the toll exacted by dentistry on those who practise it will have been proved to the hilt.

39. A more detailed examination of the 1931 Decennial Supplement shows that dentists returned an excess of mortality from heart diseases other than valvular (25 per cent above the standard) and from suicide (78 per cent above the standard). What will be shown in the volume now in process of preparation by the Registrar-General cannot be predicted, but one thing which can unfortunately be said with certainty is that heart trouble in one form or another has been the cause of death of a considerable number of dentists in recent years.

40. Clearly, what has been said in this section of the Memorandum must be regarded as conjecture until such time as comparatively recent statistics are available for examination, but the Association will be very surprised indeed if those statistics tend to disprove the statements and contentions which have been made.

PART V

SHORTAGE OF DENTAL MAN-POWER

The McNair Report

41. It is known that the members of the Royal Commission will have studied the Report of the McNair Committee, which Committee, in arriving at their conclusions, took into consideration information obtained from a host of sources and also paid particular attention to the interim and final Reports of their predecessors, the Teviot Committee. There will, therefore, be no object in the Association categorising the reasons which led the McNair Committee to confirm emphatically that there is indeed a shortage of dentists which is likely to be accentuated within the next few years. What is desirable, however, is to draw attention to certain aspects of the McNair Report and certain points mentioned in the document which, in the Association's view, have a direct bearing on the remuneration question.

Committee refer to the bad press received by the profession and say that "much publicity has been given to the apparently very high remuneration of some dentists in the early days of the National Health Service with the suggestion that these earnings were out of all proportion to their deserts and were at the public expense." After mentioning other matters which were given unwarranted prominence in the Press, the McNair Committee go on to say "we agree that the profession appear to have been harshly treated by the Press and unjustly and we cannot help feeling that had the true facts been made more readily available to the public in a proper form at the right time, much of this adverse publicity might have been avoided or countered."

Attitude of the Dental Profession: Influenced by Sense of Insecurity

48. In paragraph 68 the McNair Committee, harking back to their earlier references in paragraphs 30 and 60 to the attitude of dentists themselves as a factor in recruitment said that they received a good deal of evidence showing that "one cause of the present discontent in the dental profession is a feeling of uncertainty as to their financial future which has resulted from three reductions made in the remuneration of dentists working in the National Health Service since its introduction in 1948." The next sentence in this paragraph is particularly significant bearing in mind not only the context from which it is taken but also the claim by the Association, which, together with that submitted on behalf of the medical profession, was the primary cause of the establishment of the Royal Commission. The sentence reads "This effect has been accentuated by the fact that these reductions have occurred at a time when the value of money has been steadily declining and almost every citizen has experienced difficulty in the adjustment of his personal budget." The paragraph concludes with an expression of opinion that "a feeling of financial uncertainty as to the future is a factor which cannot be ignored when seeking to enlist the full co-operation of a profession in a national effort to bring about a substantial increase in its numbers."

Man-power Requirements

49. The McNair Committee was set up, of course, for the specific purpose of enquiring into the reasons for the lack of candidates of suitable calibre for training as dentists and indicating possible directions in which remedies might be sought. To a considerable extent the work the McNair Committee were called upon to perform was akin to that of the Teviot Committee, who had, however, a much wider remit. The Teviot Committee did make specific recommendations as to the desirable intake of newly qualified dentists per annum, and the figure they suggested was 900. The term "newly qualified dentist," however, is somewhat misleading because what the Teviot Committee really had in mind was that the professional intake each year should be 800, allowance being made for failure to qualify by about 100 students per annum. The McNair Committee's target is somewhat higher, as they advocate an increase from 650 to 1,000 of the total number of places in the dental schools for first-year students. They visualise that if and when their recommendations in this respect are implemented, an effective addition to the practising strength of the profession in Great Britain of rather more than 800 dentists annually will be produced. In arriving at this estimate the McNair Committee, like the Teviot Committee, allow for a wastage of probably 100 students each year, and they also allow for the continued admission of foreign students.

50. So far as the recruitment position is concerned, the following table, taken from the Kelsall Report, is illuminating:

Academic Year 1955-56	Male		Female		Both	
	Home	Overseas	Home	Overseas	Home	Overseas
Admitted	452	77	95	7	547	84
Not admitted	263	76	53	9	316	85
Total	715	153	148	16	863	169

From the above table two facts emerge: firstly, even if all the "home" candidates had been acceptable as students and places had been available for them, the number of admissions would still have fallen very substantially short of the McNair Committee target of 1,000, and secondly, disregarding "overseas" admissions, the number of candidates actually accepted was little more than half the essential optimum. There can therefore be no question that it is necessary to encourage, and continue encouraging, recruitment to the dental profession by every possible means, and further that it is of paramount importance that additional accommodation for dental students, as advocated by the McNair Committee, be provided at the earliest possible moment.

Quantity and Quality of Newly Qualified Dentists

51. The Commission have enquired as to the quantity and quality of newly qualified dentists. The 1957 Dentists Register shows that during 1956 665 names were added to the Register, i.e. there were 665 new registrations as distinct from names restored, of which there were 129. In consideration of these figures two points should be borne in mind: firstly, the new registrations included 122 Commonwealth dentists, whose stay in the United Kingdom is more likely than not to be of short duration, and, secondly, there were 682 names removed from the register in 1956. In connexion with the question of quality difficulty arises, however, because the Association fail to see what can be regarded as being the criterion for assessing quality. What, indeed, is meant by quality? With the exception of a very small number of foreign dentists admitted to the Register, newly registered practitioners will have passed University courses of full-time study, which, as has been explained previously, are of high standard, but it is of course not known by what margin above the minimum passmark each candidate succeeded in qualifying. Further, any enquiry with the object of eliciting that information would not only be fraught with difficulty but would also be both pointless and undesirable because in dentistry, as in other professions and occupations it does not necessarily follow that the student who passes his examinations with flying colours will prove to be superior in the pursuit of his profession to those who finished below him.

Wastage During Training and after Qualification

52. The remaining question on this subject of man-power which the Royal Commission have asked concerns wastage during training and in the first few years after qualification. So far as wastage during training is concerned, this question was gone into by both the Teviot and McNair Committees, who concluded that approximately 10 per cent of dental students would fail to complete the course, and this would still seem to be a reasonable estimate. Wastage after qualification is something concerning which it is more difficult to obtain reliable information, unless it be from the General Dental Council, who may have some record of the numbers of practitioners who cease to be registered within a few years after the first entry of their names. It is known, however, that the Canadian Dental Association receive enquiries at the rate of about 300 per year from British dentists contemplating emigration to and ultimate practice in Canada. Furthermore, enquiries relating to practice in Canada, the United States, Australia and other countries are frequently received at the British Dental Association Headquarters. This state of affairs is unfortunate to say the least, bearing in mind the dental man-power situation which, as has been shown, is such that the country cannot afford to lose the services of even one man or woman. Finally, with regard to newly qualified practitioners whose birthplace is in the Commonwealth or a foreign country (and who are understood to constitute some 9 per cent of the present dental student strength), the Association believe that almost all the foreigners and most Commonwealth dentists return to their own countries within a comparatively short period of qualifying.

NOTE.—"Application for admission to Universities—Report of an Enquiry commissioned by the Committee of Vice-Chancellors and Principals of the Universities of the United Kingdom" by R. K. Kelsall, published June, 1957."

to the profession." The remit was extended while the Committee were still sitting to cover the remuneration of dental specialists and consultants: this extension made the Spens dental remit comparable with the remits of the Spens Medical Committee and the Spens Committee on the Remuneration of Consultants and Specialists.

Money Values

60. The Spens Dental Committee expressed their recommendations in terms of net remuneration and of 1939 values of money. They also decided, as had the Spens Medical Committee previously, that they were not qualified to form an opinion on the adjustment of pre-war incomes that would be required to produce corresponding incomes post-war. They endorsed the views of the Spens Medical Committee which were as follows:

"We leave to others the problem of the necessary adjustment to present conditions, but we would observe in this connexion that such adjustment should have direct regard not only to estimates of the change in the value of money, but to the increases which have in fact taken place since 1939 in incomes of other professions. In our judgment, it is only if corresponding changes are made in the incomes of general practitioners that the recruitment and status of their profession will be maintained as against these professions."

Intended Parity in Medical and Dental Betterment

61. In a letter dated June 14, 1948, written by Sir Will Spens to Miss (now Dame) Enid Russell Smith of the Ministry of Health in answer to a query on superannuation which had been raised by the Association, the following statement appears:

"It is clear that, in the comparison made in the Dental Committee's Report between the recommended net incomes in the two Reports (Medical and Dental) the two sets of recommendations were regarded and treated as comparable except in so far as attention was expressly drawn to certain minor differences. It seems to me to follow that the Dental Committee's Report was made on the assumption that both sets of recommendations would be subject to appropriate and similar betterment to allow for the difference between 1938 and 1948."

After comments on another question entirely, the letter continues:

"I ought perhaps to guard myself against a possible misunderstanding of what I have just said as to betterment. I am clear that the comparison in the Dental Committee's Report between the recommendations in the two Reports implies the assumption that the betterment factor in respect of net incomes would be similar in the two cases. This, of course, is not only consistent with a difference in the betterment factor in regard to gross incomes but is likely to involve such a difference."

These comments by the Chairman of the three Interdepartmental Committees on the remuneration of doctors and dentists are of great significance and will be referred to subsequently.

Recommended Limitation of Dentists' Working Hours

62. Although there were considerations affecting both the medical and dental professions there were also problems peculiar to dentistry upon which the Spens Committee commented. They said that they were "in no doubt that the practice of dentistry is exceptionally arduous, involving as it does the performance by a dentist of intricate manual work at the chairside" and were "impressed by the unanimity of evidence as to the strain upon a practitioner" which they were convinced "imposes a very real limit upon the number of hours that a dentist can be expected to work at the chairside without loss of efficiency". The Committee reached the conclusion that thirty-three hours a week by the chairside or, say, 1,500 chairside hours a year, together with nine non-chairside hours per week represented full employment and that generally speaking employment in excess of these hours tended to impair efficiency.

Chief Source of Evidence

63. Before proceeding further it is desirable to comment on the chief source from which evidence was obtained by the Spens Dental Committee. Reference has been made in paragraph 1 of Part I to the amalgamation, as the present British Dental Association, of the three dental organisations which existed prior to 1949: it was those three organisations who collectively, through what was known as the Dental Consultative Committee, obtained, collated and included in their own Memorandum of Evidence the very detailed statistics as to pre-war incomes which clearly were of great assistance to the Spens Committee.

Recommended Income Levels when no shortage of Dentists

64. The Spens Dental Committee, having had regard to the considerations referred to in paragraph 62, expressed the opinion that the pre-war average net incomes of dentists were inadequate when regarded in the light either of the value of the services rendered by dental practitioners to the community, or of the importance of maintaining and improving recruitment to the profession. They accordingly advocated increases to stated levels of the average net incomes of specified age groups, in the same way as did the Spens Medical Committee: there was the proviso, however, in the cases of dentists that those income levels should only be operative when there was "a supply of dentists sufficient in relation to the demand for their services".

65. This particular recommendation appears as sub-paragraph (i) of paragraph 32 on page 11 of the Spens Dental Report and it is abundantly clear that the purpose of the Spens Committee in including it was to provide for a situation such as that which existed before the Second World War, i.e. one in which there was no shortage of dentists. That situation does not obtain at the present time, nor is it likely to for years to come; therefore for all practical purposes this particular Spens recommendation has no relevancy.

Recommended Basic Net Income while Deficiency in Dental Manpower Exists

66. Visualising that there would indeed be a shortage of dentists arising from the introduction of the National Health Service, and from greater enlightenment of the public as to the value of dental health, the Spens Dental Committee were not "content merely to make recommendations which may well have little or no relevance to the actual circumstances". They came to the conclusion that they could "best meet the difficulty by making a recommendation as to the remuneration of an experienced single-handed dentist, working efficiently and making full use of all appropriate assistance, fully employed but not working longer hours" than those indicated in paragraph 62 and their recommendation was that the remuneration in the circumstances mentioned should be a net annual income of £1,600 in terms of 1939 values. The Committee recognised that "if the profession were seriously understaffed having regard to the demands on their services, the incomes of an abnormally high proportion of practitioners may tend to centre round the figure of £1,600".

Additions to Basic Income

67. The Committee went on to say "we should not be satisfied if there were no possibility of dentists in general practice earning more than the net annual income which we recommended above. In the past, differentiation in incomes has been secured, in part, by variations in the fees charged by dentists. We have to recognise that this method of differentiation may not be permissible in a public organised service. We have therefore considered other methods by which higher incomes may be earned by a proportion of practitioners". The Committee expressed the view that more than £1,600 a year could properly be earned by experienced practitioners in partnership, or by the employment of salaried assistants. They also believed that the limitation to 33 hours per week at the chairside should not be rigid, but that a certain number of dentists, especially among those below middle age, could and would work more than 33 chairside hours without loss of efficiency. The Committee envisaged that the proportionate net income from an extra half-hour five days a week would be a little over £120 and from an extra

hour five days a week a little over £240, but that actual increases in net income might be larger than anticipated owing to variations in expenses.

Wrongful use of Income Levels Recommendation as Criterion

68. There is no shadow of doubt that the two Spens recommendations which have been the subject of comment in paragraphs 64, 65 and 66 were respectively intended to apply in entirely differing sets of circumstances. It is equally beyond question that the recommendation which should be applicable in the circumstances which exist today, i.e. when there is an undeniable shortage of dentists, is that contained in paragraph 32 (ii) of the Spens Report (i.e. the recommendation dealt with at length in paragraph 66) with due regard to the succeeding recommendations. Despite these self-evident facts, part of what is said in Spens Recommendation 32 (i), i.e. the income levels recommendation, has been used comparatively recently by the Ministry of Health as a yardstick in the determination of payments to general dental practitioners.

69. The occasion arose in 1955 when the Association were supplied by the Ministry of Health with a document setting out the conclusions reached by the Health Ministers in the light of the fact finding enquiry into the incomes and expenses of National Health Service general dental practitioners during 1952-53, which had taken place with the co-operation of the Inland Revenue and the Association themselves. In that document it is stated that the Ministers were "influenced by the fact that even with the reduction (of 10 per cent) in operation, single-handed dentists (without assistants) in the 35-54 age group achieved net incomes which if the Exchequer Superannuation contribution is included, were on an average not much less than £2,000 a year." The view of the Association was and still is that it was entirely wrong that in an assessment of the dental remuneration position regard should be had, as it undoubtedly was, to a recommendation of the Spens Committee which was intended to apply only in entirely different circumstances. The second recommendation, i.e. that relating to single-handed practitioners, was all-embracing and made no reservations with regard to practitioners' ages. The intention clearly was that no matter how old a practitioner might be, if he fulfilled the conditions laid down in this recommendation he should be able to earn the income advocated therein, in 1939 money values.

Basis of 1948 Scale of Fees for General Dental Practitioners

70. It was in the light of the Report of the Spens Dental Committee, and in particular of the recommendation concerning single-handed practitioners, that the scale of gross fees for general dental practitioners in the National Health Service, which became operative on July 5, 1948, was devised. The scale, although not agreed in its entirety between the Minister of Health and the Dental Consultative Committee, was intended to yield a net income of £1,778, i.e. the Spens advocated remuneration of £1,600 for thirty-three hours' chairside work per week plus 20 per cent (alleged by the Ministry of Health to be appropriate recognition of changes in money values between 1939 and 1948) less 8 per cent set aside as the Government Superannuation contribution. The fluctuations in remuneration since the inception of the Health Service will be dealt with more specifically in the next Part of this Memorandum, but it is appropriate to mention here that the original scale of gross fees was superseded in June, 1949, by a new scale giving, overall, 20 per cent less gross remuneration and that this scale, in turn, was cut by 10 per cent from May, 1950 to May, 1955. The disastrous effect on net incomes of these reductions is shown in paragraph 76. The 10 per cent cut was abolished in May, 1955, on condition that a revised scale would be negotiated in such a way as to ensure that, for the same volume of work as in 1952-53 (the enquiry year), the average net income resulting therefrom would approximate to that which would have been earned in 1952-53 if the 10 per cent cut had not then been in operation. Comment on the 1955 agreement and the ensuing negotiations, which produced the scale now in operation, will be made in a succeeding Section of this Part of the Memorandum.

Betterment Intentions of Spens Dental Committee not made Effective

71. It is now necessary to revert to the comments made by Sir Will Spens in his letter to Dame Enid Russell Smith of June 14, 1948: these comments were quoted in paragraph 61. The wording of the letter in question makes it crystal clear that the intention was that medical and dental betterment should be the same, but the intentions of the Spens Committee were never fulfilled. The Association's representatives were given to understand during the course of negotiations concerning the initial scale in May, 1948, that the betterment factor of 20 per cent arbitrarily applied in the dental case was in fact that offered to the medical profession and based upon an examination made by the Ministry into alterations in the value of money and increases in incomes of other professions since 1939. The Association's negotiators were also told that if the doctors succeeded in obtaining a higher betterment factor, the dentists would get the same. The views of the Ministry were not accepted by the Dental Consultative Committee, but owing to the very limited time (two weeks) allowed for discussions of the Scale of Fees to operate at the commencement of the National Health Service on July 5, 1948, negotiations between the Ministry and the profession's representatives were never completed. The 1948 Scale therefore was largely an imposed Scale.

72. Even assuming that medical betterment and dental betterment were originally the same, and this is by no means certain, that position certainly no longer obtained when the award to the medical profession by Mr. Justice Danckwerts became effective: under that award, medical betterment applied retrospectively became 85 per cent from 1948 to 1951, and 100 per cent from 1951 onwards. Moreover, since then the relative position of dental practitioners has worsened considerably for other reasons. The 1948 Scale was intended to give effect to the Spens single-handed practitioner recommendation, but with allowance only for the 20 per cent betterment arbitrarily decided upon by the Ministry of Health: the chequered history of dental remuneration since 1948 will be dealt with in more detail in the next Part of this Memorandum, but it is pertinent to point out that with the introduction of the 1949 Scale not only was the 20 per cent betterment taken away from the profession but a further 20 per cent as well, because the reduction of 20 per cent effected by the 1949 Scale was in gross fees, involving twice as large a percentage reduction in net incomes. Furthermore, from May, 1950 to May, 1955, an additional cut of 10 per cent from the 1949 gross fees was in being, with the same effect as before in relation to net incomes.

73. It will be gathered that, so far as general dental practitioners are concerned, the recommendations of the Spens Committee never have been implemented in the manner in which they should have been. This remark has relation purely to those aspects of the Report of the Spens Committee on the remuneration of general dental practitioners which concerned the dental profession alone: the Association are mindful, however, of the dispute between the British Medical Association and the Government concerning the interpretation of the comment by the Spens Committee for General Medical Practitioners which was repeated in paragraph 7 of the Spens Dental Report. The relevant remarks of the Spens Committee have already been quoted in paragraph 60 of this Memorandum and it need hardly be said that the view of the British Dental Association is that the medical and dental professions were certainly led to believe that there would be periodical adjustment of their remuneration to meet changed conditions and they cannot accept the contention of the Government that the Spens Committee's comments were intended to apply only at the particular time and in the particular circumstances in which they were made. Such a contention is indeed completely refuted by the very wording of the remit of the Spens Dental Committee, which has been quoted in paragraph 59. The significant part of the remit in the present connexion is that which reads "with due regard to what have been the normal financial expectations of general dental practice in the past and to the desirability of maintaining in the future the proper social and economic status of general dental practice and its power to attract a suitable type of recruit to the profession."

SECTION III—THE EFFECT OF LEGISLATION AND REGULATIONS

Scales of Fees for General Dental Practitioners

74. In their claim for substantial improvement in the remuneration of National Health Service dentists, which was submitted to the Minister of Health and the Secretary of State for Scotland in February 1957, the Association include an introductory paragraph in which are listed the Acts and Regulations which have governed the remuneration of general dental practitioners from the Service vesting day (July 5, 1948) to 1955. For ease of reference, and with a view to subsequent argument, the list is repeated below and it will be found that there are additions to it in order to bring the position up to date:

- (a) July 5, 1948—Inception of National Health Service.
- (b) July 5, 1948—National Health Service (General Dental Services) Fees Regulations, 1948.
- (c) Feb. 1, 1949—National Health Service (General Dental Services) Fees (Amendment No. 2) Regulations, 1948.
(Confiscated half gross earnings over £400 per month)
- (d) June 1, 1949—National Health Service (General Dental Services) Amendment (No. 2) Regulations, 1948.
(Cancelled (c): reduced Scale of Gross Fees under (b) by approximately 20 per cent).
- (e) May 1, 1950—National Health Service (General Dental Services) Fees (Amendment) Regulations, 1950.
(Reduced Scale of Gross Fees under (d) by 10 per cent).
- (f) May 10, 1951—National Health Service Act, 1951.
(Imposed charges to patients for dentures).
- (g) May 22, 1952—National Health Service Act, 1952.
(Imposed charges to patients for treatment).
- (h) June 15, 1954—National Health Service (General Dental Services) Regulations 1954.
(Consolidating previous N.H.S. Regulations including (d)).
- (i) May 1, 1955—National Health Service (General Dental Services) Amendment Regulations, 1955.
(Cancelled the 10 per cent reduction in gross fees imposed under (e)).
- (j) April 1, 1957—National Health Service (General Dental Services) Amendment Regulations, 1957.
(Superseded 1949 Scale, but with same financial effect).
- (k) May 1, 1957—National Health Service (General Dental Services) Amendment (No. 2) Regulations, 1957.
(Authorised 2.6 per cent increase in gross fees).

Timing of Dental Operations—The Penman Report

75. Reference has been made earlier to comments by the McNair Committee on the sense of insecurity felt by many practitioners following cuts in their remuneration at a time when persons in other occupations were receiving increases and the value of money was falling. Particularisation may be of assistance and reference must first be made to the fact that the original scale assumed that a certain time would be involved in the performance of each dental operation in that scale. In 1949, a Government-appointed Committee, under the Chairmanship of Mr. William Penman (referred to briefly in paragraph 34), investigated this question of timings in detail and the Report of that Committee substantiated almost in toto the timing which had been first assumed.

Cuts in the Scale of Fees—Unilateral Action by the Government

76. The Government of the day had, however, decided without waiting for the Penman Report to cut the 1948 scale of fees and this was first done in February

1949 when regulations were introduced limiting earnings to certain levels, regardless of the amount of work done to achieve those earnings. Not satisfied with this, the Government four months later introduced fresh regulations cutting the 1948 Scale by 20 per cent gross or approximately 40 per cent net. Notwithstanding the publication of the Penman Report, which has been accepted almost in entirety by the Government, a further cut was made on May 1, 1950, this time of the order of 10 per cent gross, or about 20 per cent net. The effect of these two cuts on net remuneration is difficult to evaluate, but the position can be illustrated by a simple example. A man whose gross remuneration was £3,858 per annum (see paras. 83 and 101) at the time of the 1949 reduction found his net income reduced to £1,007 per annum, assuming he could not make any immediate reduction in expenses. With the introduction of the 1950 cut, again assuming no reduction in expenses, his net income must have been further reduced to £699 per annum. The following table should make the position absolutely clear:

					<i>Exes</i> (52 per cent of £4,000; see para. 101)		<i>Net</i>
					£	£	£
Basic	...	...	...	...	3,858	2,080	1,778
20 per cent cut	...	...	...	...	771		
					<hr/>		
Leaving	...	...	...	...	3,087	2,080	1,007
10 per cent cut	...	...	...	...	308		
					<hr/>		
Leaving	...	...	...	...	2,779	2,080	699

It may well have been that some reduction in expenses was possible, perhaps by the discharge of staff, but in view of the fact that the recent 2.6 per cent gross increase was publicised as a 5 per cent net increase, clearly assuming no increase in expenses, it is logical and reasonable to assume no reduction in assessing the effects of cuts in the scale.

Effect of Charges to Patients

77. With this explanation, consideration can now be given to the effects of the various measures listed in paragraph 74 on the actual remuneration of general dental practitioners. The effect of the various cuts, bearing in mind what has been said previously, will be apparent, but it must also be remembered that for quite a long time the introduction of charges to patients, firstly for dentures and afterwards for treatment, adversely affected the dental profession in that charges discouraged those in need of treatment from obtaining it. The monetary results are set out on page 7 of the Association's Claim. It will be obvious from the figures given that the imposition of charges certainly achieved a saving of Exchequer funds, but only at the expense, literally, of general dental practitioners and at an untold cost to the dental health of the nation.

Categories of Practitioners

78. In another part of the Claim, on page 7, the average payments per principal in each financial year from April 1949 to March 1956 are shown. In case there should be any misunderstanding as to the meaning of the word "principal" it may be helpful to explain that while the great majority of dentists in general practice work single-handed, apart from the employment of ancillary staff such as dental technicians and chairside attendants, there are some practitioners who employ other dentists as their assistants and others who enter into partnership arrangements with colleagues. Such references to principals as may appear in the Claim or elsewhere should, therefore, be taken to refer to principals of practices whether they be single-handed or employing assistants, or in partnership. Where figures for principals are quoted, however, it must be borne in mind that those figures are derived from the work of larger numbers of dentists than there are principals.

Average Net Remuneration 1955/1956

79. On net figures alone, as applied to principals and not simply to single-handed practitioners, it would appear on the face of it that, by March 1956, when general dental practitioners had been back on the 1949 scale for some little time following the restoration of the 10 per cent in May 1955, average net remuneration was nearing restoration to the 1949 level. During the year April 1955 to March 1956, the gross fees authorised in Great Britain totalled £38,864,517 this amount having been distributed between 9,604 practice principals (see paragraph 78). The gross average per principal derived from the two figures quoted is £4,047, and the resultant net average, assuming a 48 per cent expense ratio, is £2,100.

Expense Ratio Assumed for Calculation Purposes

80. It may be asked why an expense ratio of 48 per cent is assumed. This percentage is taken purely as a basis of calculation, which does not mean that the Association subscribe to its accuracy, because 48 per cent would have been the average expense ratio in 1952/53 had the 10 per cent cut not then been in operation. The reasons for this statement will be given in the Section dealing with expenses as such, but this much more must be said now: it is perfectly obvious that since 1952/53 expenses by way of heating, lighting, payments to dental laboratories, wages of staff, in fact, expenses generally, have risen considerably. Despite this, in awarding a 2.6 per cent gross increase to general dental practitioners, effective from May 1, 1957, the Ministry of Health have taken it that the expense ratio is still 48 per cent. Until a further enquiry into incomes and expenses, agreed to by the Association and to be conducted by the Inland Revenue, has taken place and results are available for study, the true average expense figure cannot be determined but even if it should prove to be 48 per cent it would be illusory because the Ministry of Health could not deny that it could only result from the performance of a greatly increased volume of work as compared with what may be termed, for the immediate purpose, the "standard" year 1952/53. For the same volume of work as in that year the expense ratio must inevitably be very much higher than it was four years ago.

81. In consideration of the net figure of £2,100 quoted at the end of paragraph 79 it should be appreciated that quite apart from the fall in the value of money, and from the fact that it does not represent basic income, it is achieved only by taking into consideration the incomes of practitioners of all types, i.e. whether single-handed, employing assistants or in partnership. £2,100 may have represented the average net income of the 9,604 principals who were providing General Dental Services in Great Britain on January 1, 1956, but it was only attained as the result of the work of approximately 11,000 practitioners. Moreover, it should not be forgotten that the Spens Dental Committee, as pointed out in paragraph 67, envisaged that substantially higher incomes than that which the Committee regarded as basic, i.e. £1,600 plus betterment, could properly be earned by experienced practitioners in partnership, by the employment of assistants and by hours of work above the norm of 33 in some cases.

Single-handed Practitioners

82. The crux of the matter, however, is the income position of single-handed practitioners. As pointed out on page 8 of the Association's claim, there is no up-to-date evidence available in this connexion, but it is reasonable to assume that the relationship between average earnings of all principals and those of single-handed dentists remains approximately as in 1952/53: this means that during 1955/56, when the average gross earnings of all principals amounted to £4,047, single-handed earnings (gross) probably averaged £3,480. Assuming, but not admitting, an expense ratio of 48 per cent, the net incomes of single-handed practitioners for 1955/56 for an undoubtedly greater number of hours worked must have averaged about £1,812 or about £34 more than the original (1948) scale of fees was designed to produce for single-handed practitioners working 1,500 chairside hours per year. Disregarding any fall in the value of money between 1948 and 1951 and having regard only to the percentage decrease in the five-year period 1951/56 which was covered by the Association's claim, the figures show that the

average net income of single-handed practitioners at the end of a period during which the value of money decreased by 24 per cent (relevant evidence on this point being provided in the Claim) and after the performance of a much greater volume of work than originally contemplated, was just 1.9 per cent better than the basic net income which it had been possible for those practitioners to earn on introduction to the National Health Service eight years earlier.

Basic Earnings

83. The figures given in paragraphs 79 and 82 represent average earnings: they do not indicate a practitioner's basic rate of remuneration, which is the fundamental consideration. This can be readily calculated, however, if as a starting basis the net income which the 1948 Scale was intended to produce for 1,500 chairside hours work per year is used. The amount in question was £1,778, this, allowing for an agreed expense ratio of 52 per cent and deduction of the Exchequer superannuation contribution of 8 per cent, being derived from a scale of fees designed to produce gross earnings of £3,858 per annum (see paras. 76 and 101). The gross fees were reduced by approximately 20 per cent by the 1949 Scale, which operated from June 1949 to April 1950, and from May 1955 to March 1957: the Scale in operation since April 1, 1957, was designed to produce by counter-balancing variations in fees the same financial results as the 1949 Scale. The resultant gross figure is £3,087 and after adding the recent 2.6 per cent gross increase and assuming constancy of expenses (see paragraph 76), the net basic income arrived at is only £1,087. This indicates that in 1957, nine years after the introduction of the Health Service, a dental practitioner's basic net reward for 1,500 hours' chairside work is nearly £700 less than the amount (£1,778) originally intended to give effect to the Spens Committee recommendation: that amount, it must be remembered, was itself inadequate because of Government insistence on a betterment percentage which had no semblance of reality.

Cost of the General Dental Services—The Guillebaud Report

84. All that has been said above relates to dentists' earnings, but it should not be overlooked that payments to dentists and cost to the Exchequer are not synonymous because patients have to meet part of the cost of dentures and treatment. The effect, so far as the payments from the Exchequer are concerned, was that as compared with actual expenditure on the dental services in England and Wales during 1949/50 of £46 million, in 1953/54 the actual expenditure was as low as £21,470,000. It is not without significance that the fall in the cost of the dental service tallied almost exactly with the reduction of £24 million in the cost of the Executive Council services in general, which was noted by the Guillebaud Committee in paragraph 38 of their Report. Later in their Report (paragraph 92) the Guillebaud Committee pointed out that the "real" net cost of the National Health Service in 1953/54 was only £11 million greater than in 1949/50, and added that when allowance was made for a rise of nearly 2 per cent in the population during the period under review, the cost per head, if there had been constancy in prices, would have been almost exactly the same in 1953/54 as in 1949/50. It is relevant to point out that when the Guillebaud Committee referred to "real" cost they were having regard to 1948/49 price levels: the year 1953/54, which was the latest to which the Guillebaud Committee were able to turn for figures, has long since passed but general dental practitioners in the National Health Service are still being paid not just at 1948/49 "prices" but, even allowing for the recent small percentage addition to gross fees, at nearly 18 per cent less.

Comment on Government Attitude

85. In the succeeding Sections of this Part of the Memorandum the special circumstances arising from the 1955 agreement and the vitally important questions of expenses and hours of work are dealt with, but one final comment is necessary under the present heading. It is highly improbable that any other wage, salary or fee-earning section of the community has had to endure within the space of

nine-years the effects of eleven Government measures, introduced either by legislation or by regulation, directly influencing their standard of living and the pursuit of their profession, trade or occupation. It is certain that such measures would not, indeed could not, have been taken if they had been designed to affect directly or indirectly the welfare of members of an organisation other than one composed of professional men and women whose code of ethics and sense of public responsibility make the idea of striking anathema to them.

SECTION IV—THE 1955 AGREEMENT

Background to the 1952/1953 Enquiry into Incomes and Expenses: Cuts in the Scale of Fees

86. It is desirable to clarify the reference to the 1955 agreement and this can only be done by giving the history of events which led up to that agreement. The agreement was the outcome of the 1952/53 enquiry into incomes and expenses, which had resulted from endeavours by the Association to persuade the Minister of Health to abolish the 10 per cent cut which had been operative from May 1, 1950. This cut, it must be explained, was imposed on grounds of national economy, it being argued that the dental service was costing too much. This bland contention completely ignored the fact that, in the face of repeated warnings by the Association, the Government had so underestimated demand for treatment when the Health Service began that they allowed for expenditure from July 1948 to May 1949 of only £7,000,000, which contrasted oddly with the actual expenditure for the period of £18,000,000. Faced with this situation, the Government, ignoring the fact that the level of expenditure should have been foreseen in the first place and in any event only represented proper payment for work done, promptly cut the Scale of Fees in February 1949; introduced a reduced scale in June 1949, and, finally, as shown, imposed the 10 per cent cut in May 1950.

Extent of the Enquiry

87. The Minister of Health, despite the fact that expenditure on the dental services had fallen consistently from 1949, as the result of cuts in fees and of the introduction of charges for dentures and for treatment and that practitioners' incomes were likewise considerably reduced, insisted on the holding of an Enquiry before he would give serious consideration to the Association's request. The Enquiry was conducted, with the Association's agreement, through the Inland Revenue and also by questionnaire sent by the Association direct to general dental practitioners whose names were on Executive Council lists. The Inland Revenue Enquiry covered 2,350 practitioners, but information relating to only 1,075 became available for analysis: this was because there were many cases where practitioners concerned were not practising on their own account (i.e. they were employed as assistants); where accounts were not available, or did not end on a date covered by the Enquiry; or where by reason of cessation or commencement of practice the accounts did not cover a full year. The same consideration applied to an even greater extent to the Association's own enquiry for questionnaires were sent to 4,700 practitioners whose names were on Executive Council lists, but information relating to 1,370 only was eventually usable.

Results of the Enquiry

88. The tables of payments which appear on page 7 of the Association's Claim provide proof of the contention that dental gross and net incomes fell consistently and substantially from April 1949 to March 1953. They do not show, however, the actual net incomes which were earned, at least for the last three years of the period, because for purposes of comparison it has been assumed in the tables that the 10 per cent cut had not taken place. It is important, however, that the true position in 1952/53 should be appreciated and there is, therefore, set out below a table which represents the agreed results (i.e. agreed between the Government Actuary and the

Association's Actuary, and accepted by the Ministry of Health) of the Enquiry into incomes and expenses which took place early in 1954:

Great Britain Category	1952/1953 Gross income	Expenses=	Difference net income	Expense ratio
	£	£	£	per cent
Principals, single-handed	2,875	1,530	1,345	53.2
" employing assistant dental surgeons	7,160	4,595	2,565	64.2
" in partnership	3,715	1,755	1,960	47.2
All	3,345	1,790	1,555	53.5

(NOTE.—For clarification of Categories, see paragraph 78.)

It will be seen that the average net income of single-handed practitioners in 1952/53 was only £1,345 which was over £400 less than the basic income, plus betterment, which single-handed practitioners had reason to expect they would be able to earn and in fact were able to earn from July 1948 until February 1949 when the first reduction in payments to general dental practitioners was introduced.

The Ministry Argument and Offer

89. As mentioned, the amalgamated results of the two Enquiries were agreed between the Government Actuary and the Association's Actuary: this was at the end of September 1954, but it was not until March 17, 1955, that the Association were given an indication of the intentions of the Minister of Health and the Secretary of State for Scotland. On that day the Association's representatives were confronted with the statement which has been referred to briefly in paragraph 69. After the quite unfair and irrelevant contention concerning earnings of single-handed dentists in the 35-54 age group, the statement continued with an indication that "as a full settlement of dental remuneration at the present time, a revised scale should be worked out on a basis that would produce a substantially higher net income than was achieved in the Enquiry period 1952/53." The statement continued: "the aim should be to produce net incomes comparable—having regard to the volume of work, and by that is meant the amount done and the time necessarily spent in doing it—with the net incomes that would have been earned in the Enquiry period had the 10 per cent reduction not then been in force." Further reference to the tables of payments on page 7 of the Association's Claim will show that this was in effect an attempt to create an average, and not a basic, norm for single-handed practitioners. True, the Ministry document went on to make it clear that for a larger volume of work than had been performed in the year 1952/53 proportionately greater incomes would result and vice versa, but nevertheless the intention clearly was to create a norm which was a debasement of that on the promise of which the bulk of the profession entered the National Health Service.

90. Despite the obvious pitfalls of an agreement on the basis proposed by the two Ministers, the Association entered into it because they could see no practical alternative, it being obvious that in the absence of such an agreement general dental practitioners in the National Health Service would continue to be paid in accordance with the 1949 Scale less 10 per cent. Upon receiving the Association's assurance that they would fulfil the terms of the agreement, i.e. co-operate in the production of a revised scale on the basis visualised, the Minister introduced Regulations effective from May 1, 1955, abolishing the 10 per cent cut, and those Regulations remained in operation until April 1, 1957, when there came into force the 1957 scale which was intended to be similar in overall financial effect to the 1949 scale. This latest scale represented the outcome of close on two years' negotiations over the table between the Association's representatives and officers of the Ministry, these protracted discussions having been necessitated by the nature of the 1955 agreement, which meant that although the narrative of the scale could be varied without difficulty, fees could not be adjusted in an upward direction without counterbalancing reductions in other fees.

Agreement by the Association with Reservations

91. In the letter which was sent to the Minister of Health consenting to the introduction of the revised Scale, the Association reserved the right to seek improvement in the remuneration of National Health Service dentists when they considered such action to be appropriate: in making this reservation, the Association had in mind the fact that in the spring of 1956 they had informed the Minister that in due course they proposed to lodge a claim for an increase in net remuneration to offset the fall in the value of money since 1951. The claim was not actually submitted until February 1957, largely because the Association felt that submission of the claim would have to wait upon the fulfilment by them of the terms of the 1955 agreement and it was not until early in 1957 that arrangements for the introduction of the revised scale resulting from that agreement were nearing completion.

SECTION V—EXPENSES

The Nature of a Dentist's Expenses (Including Capital Expenditure)

92. Gross payment figures such as those quoted in earlier paragraphs of this document may seem impressive on paper. Quite apart from the fall in the value of money, however, there are two considerations which have a definite bearing on the situation. The first is the question of expenses: the second, hours of work, will be dealt with in Section VI. A dentist commencing practice on his own account is involved in considerable initial outlay in the provision of surgery equipment, altering and furnishing premises, and installation of plumbing and other services which will not rank for immediate income tax relief. He may also have to make repayment by instalments of any capital borrowed and this can constitute a serious reduction of usable income where there are no capital reserves: indeed, it would probably be true to say that in most practices a considerable amount of money by way of capital is perpetually unrealisable. In the actual running of his practice, he certainly has to meet heavy overheads and costs: these expenses fall into two categories:

(a) Fixed expenses

- Premises —Surgery and waiting rooms, workshop (lighting, heating, cleaning, repairs, rent, rates, insurance).
- Equipment —Repairs, depreciation.
- Wages —Assistant dental surgeons (if on salary), technicians and apprentices, chairside assistants, clerical staff, receptionists, cleaners, etc.
- Miscellaneous—Telephones, flowers, periodicals for waiting rooms, subscriptions, loan interest, etc.

(b) Variable expenses

- Materials —Burs, amalgam, etc., for surgery.
Workshop materials.
- Wages —Assistant dental surgeons (if on commission).
- Payments to outside firms of technicians.
- Motor expenses.
- Printing and postages.

A consideration, more serious in dentistry than in other professions, is that the whole of the fixed expenses and some of the variable expenses still have to be met during periods when a dentist is unable to practice owing to illness or injury. So far as illness is concerned, a dental practitioner is exposed to a considerable risk of infection, by reason of his necessarily close contact with patients. In the matter of injury, a mishap such as a cut hand, which to members of most other professions would be of trifling consequence, may well render a dentist *hors de combat*.

Expense Ratios

93. During 1952/53 the average expense ratio for single-handed practitioners and indeed for practitioners in all categories was just over 53 per cent. Averages

are sometimes misleading, but in this respect they certainly are not. In paragraph 88 of this Memorandum, there are shown the agreed results of the 1952/53 enquiry into incomes and expenses, and in the last column the expense ratio of each of the various groups of dentists, i.e. single-handed, employing assistant dental surgeons, or in partnership, are shown. It will be seen that the partnerships' expense ratio was 47.2 per cent; that the ratio of an employer of assistant dentists was 64.2 per cent; that the single-handed man's ratio was 53.2 per cent; and that the overall average was actually 53.5 per cent. The Inland Revenue enquiry showed that 70 per cent or more dentists practise single-handed and the figures for single-handed practitioners were broken down into age groups: this revealed the following average expense ratios in England and Wales:

Age ...	...	...	Under 35	35-44	45-54	55-64	65 plus	All
Expense ratio	...	...	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent
			47.3	49.0	52.9	56.0	58.5	53.2

94. Expense ratios prevailing more recently cannot be determined without another Inland Revenue enquiry, to which the Association have agreed, but it must be borne in mind that, even while an enquiry is in progress, the eventual results are in process of becoming out of date. For example, since the end of 1956/57, during which year heavy rate increases became effective, dental technicians' wages have been increased by about 10 per cent, and there have been increases in charges for gas, electricity, coke and coal, telephones and postage, which inevitably affect dentists as professional men apart from the effect on most of them as householders. Finally, attention is again drawn to the vital point which was made in the last two sentences of paragraph 80 and which, because of its importance, will bear repetition here: "Until a further Enquiry into incomes and expenses, agreed to by the Association and to be conducted by the Inland Revenue, has taken place and results are available for study the true average expense figure cannot be determined, but even if it should prove to be 48 per cent, it would be illusory because the Ministry of Health could not deny that it could only result from the performance of a greatly increased volume of work as compared with what may be termed for the immediate purpose the 'standard' year 1952-53. For the same volume of work as in that year the expense ratio must inevitably be very much higher than it would have been four years ago" if the 10 per cent cut had not then been operative, and the basic net income, which is the fundamental issue at stake, must be considerably lower than it would have been at that time and in those circumstances.

SECTION VI—HOURS OF WORK

Information obtained by Questionnaire

95. The other consideration to which reference is made in paragraph 90 and of which a hint is given in the comments concerning physical and nervous exhaustion, is that of hours of work. When the Association conducted their 1952-53 enquiry, by agreement with the Ministry of Health, they included in their questionnaire a question asking for information as to hours of work including non-chairside hours, and averaging the figures given by the 1,370 dentists who answered this question produced for single-handed practitioners in England and Wales a figure for the year of 2,111 hours and for those in Scotland a figure of 2,220 hours. These figures must be compared with the Spens' recommended chairside hours, plus non-chairside hours reckoned by Spens to be 9 per week for a 46-week year giving a grand total of 1,932 hours.

Increases in Volume of Work

96. The volume of work undertaken in the National Health Service by dentists has risen substantially since 1952-53, because that was the year when the effect of the introduction of charges was at its greatest. A reasonably accurate idea of the position and indeed of how the position had varied since the National Health Service came into operation is obtainable from the Ministry of Health Report for the year ended December 31, 1955, which contains in Appendix XIX Table "A" a column devoted to "Total Courses of Treatment and Emergency Cases." For the Commission's benefit the total number of courses of treatment during the years

1949 to 1955 inclusive and also during the year 1956 (based on a statement by the Parliamentary Secretary to the Ministry) appear below:

<i>Year</i>	<i>Number of dentists on Executive Council lists</i>		<i>Courses of treatment (including emergency treatment)</i>
1949	...	9,272	7,809,000
1950	...	9,495	9,586,000
1951	...	9,657	9,965,000
1952	...	9,694	9,000,000
1953	...	9,485	8,375,000
1954	...	9,473	9,336,000
1955	...	9,599	9,924,000
1956	...	9,768	10,740,000

It should be noted that the above statistics relate only to England and Wales so that they have not a direct relationship to the income figure given in this Memorandum and in the Claim, but they do serve as an indication of the rising volume of work being performed by general dental practitioners in the National Health Service.

Increase in Hours of Work

97. From the volume of work figures and from the income figures it is obvious that hours of work must also have increased very considerably between 1953 and 1956. As the enquiry covered 1952-53, however, 1952 volume of work figures can be used as the starting basis for calculation, and the increase in work done in 1956 allowing for increased numbers of dentists was very nearly one-fifth. On this basis, single-handed dentists in England and Wales must have worked for over 2,500 hours in all, or 54 hours per week including non-chairside hours, assuming a 46-week working year. These hours are far in excess of those thought by the Spens Committee to be reasonable and even if it may be argued that the existence of the National Health Service has shown that dentists can work longer hours than those thought appropriate by the Spens Committee, it can scarcely be contended that the continued working for such long hours as those which are obviously being worked is in the best interests of the profession or the public. So far as members of the profession are concerned, if they slacken off they will reduce their earnings which, for the services rendered and bearing in mind present money values, already fall short of what is right and desirable, and they will also antagonise the public and the Press by failure to meet what in recent years has been the ever increasing demand for treatment.

SECTION VII—SPECIAL CONSIDERATIONS

Relative Advantages and Disadvantages of Practice in Different Fields of Dentistry

98. The broad picture of dental remuneration so far as dental practitioners in the National Health Service are concerned has been given in the earlier sections of this part of the Memorandum but the Royal Commission have asked for the Association's views on a number of points which warrant special mention. Some have been covered by comments in earlier parts of this memorandum, but others have not and the first of these relates to the relative advantages and disadvantages, financial or otherwise, of service in various fields of dentistry. This is a very difficult question to answer in precise terms for the very good reason that different dentists, like persons in other professions or occupations, may have different viewpoints: for example, and this applies particularly to women dentists, some may have a definite bent towards children's work and so seek employment in the Local Authority dental services despite the unsatisfactory levels of remuneration in that field. Other practitioners may feel that a hospital dental career, with the ultimate possibility, but not probability, of a consultant appointment, is most satisfying from their viewpoint. A small number of dentists, perhaps having had a taste of life in the armed forces during the war or National Service, may decide to make their career in that sphere of dentistry, but the main body of the profession are engaged in the general dental services or in private practice on their own account. The advantages

and disadvantages of general practice are mentioned in paragraphs 43 to 45 of this document, but it may be added that dentists, by tradition and repute, are in the main individualists and many consider that there is a deep sense of satisfaction to be gained by a man whose success depends very largely on his own initiative, even under modern-day restrictions.

99. On the question of private practice as an attraction to the profession, it is probably true that general dental practitioners in the National Health Service welcome the opportunity to do such private work as they are able, but unfortunately opportunities are limited and the reason is surely apparent. It has been mentioned earlier in this Memorandum that the National Health Service has certainly proved to be a great boon to the general public and this applies to the dental side of the Health Service just as much as to any other, although, of course, even now public appreciation of the value of dental health and dentistry is not what it should be. The point is, however, that when the National Health Service was in process of creation the Ministry of Health, no doubt with due regard to experience in the Dental Health Benefit Regulations days, but without any regard whatever to the expressed opinions of the three dental organisations then existing, estimated that the dental service from July 1948 to March 1949 would cost £7 million. They were told by the profession that the demand for treatment would be on a much greater scale and that proved to be the case with the result that the actual cost for the period mentioned was over £18 million. This made it clear that a much larger percentage of the population than had been thought (by the Government) could overcome fears arising from ignorance as to the true nature of dentistry, provided that they were not faced with an additional monetary barrier and there can be little doubt that now the general public have been nurtured on free treatment or treatment with a limited charge for nine years only a few will willingly pay more than the standard charges provided for under Acts of Parliament. In those circumstances, the opportunities of private practice available to the dental profession are necessarily limited.

Assistant Dental Surgeons

100. The position with regard to assistants in general dental practice, i.e. assistant dental surgeons, is somewhat unusual in that it is probably true to say that they are able to earn at a fairly young age incomes which may be regarded by general standards for newly qualified professional men as high. It must be remembered, however, that those amounts, inasmuch as they are normally related to whatever increase in total practice receipts is brought about by an assistant's endeavours, can only be earned as the result of the long hours of work which are common to general dental practitioners nowadays. Moreover, assistants have a scarcity value because of the dental man-power situation, which makes it possible for a comparatively inexperienced man to set up in practice on his own with good prospects of success, and also makes it impossible for a scale of payments for assistants to be established.

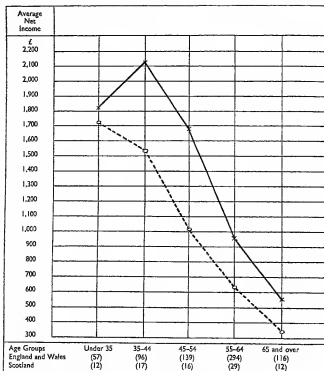
Method of Remuneration

101. It had been thought that the remit of the Royal Commission was confined to an examination of the levels of dental remuneration and that it did not embrace the methods by which those levels are achieved. The Commission, however, have asked for the Association's comments on the present system of calculating and distributing remuneration and it must be emphasised that this differs completely from the system operative insofar as payments to general medical practitioners are concerned. The medical arrangement is that following consultation between the profession's representatives and the Ministry of Health a "Central Pool" of money is made available each year by the Government for doctors providing general medical services and this "Pool" is distributed in accordance with the profession's own ideas. In the case of general dental practitioners there is no "Pool", the dentist being paid under a statutory scale of fees for each item of treatment he carries out. The method of calculating the scale of fees in 1948 was as follows: the Spens advocated figure of £1,600 was taken, and to this was added a 20 per cent betterment factor, giving a net figure of £1,920 equivalent to a gross income of £4,000 allowing for an agreed expense ratio of 52 per cent. (£4,000 less £1,920

equals £2,080 or 52 per cent of £4,000.) The figure of £1,920 was to include the net income from fees and an allowance of 8 per cent for the Exchequer superannuation contribution, so that the target net income figure became £1,778 (£1,920 less £142 i.e. 8 per cent of £1,778). Expenses having already been assessed at £2,080 a target gross income of £3,858 was thus produced. (See also paras. 76 and 83.) This was divided by the Spens figure of 1,500 chairside hours, and gave the gross figure per hour that a dentist should earn. Standard timings having been given to each dental operation, it was a simple matter to allocate a gross fee to each operation on a time basis, and thus the scale was formulated. This scale was in theory a "balanced" scale, i.e. no matter what operation a dentist was undertaking he was being paid at the same rate per hour for it.

The method of calculating the scale was defective only insofar as it allowed for an inadequate betterment factor (see paragraphs 70 and 71), but the system was

STATISTICS DERIVED FROM 1952/53 INLAND REVENUE INQUIRY INTO INCOMES AND EXPENSES OF GENERAL DENTAL PRACTITIONERS IN THE NATIONAL HEALTH SERVICE



NOTES.—(i) The continuous line relates to England and Wales; the broken line to Scotland.

(ii) The figures in brackets under the various age groups indicate the numbers of practitioners within those groups.

undermined, and the balance of the scale entirely destroyed, when the 1949 scale was introduced.

Any system of remuneration must have its advantages and disadvantages, and one disadvantage of the present scale of fees system is that the fees are quite inelastic. This was a point which the Spens Committee foresaw in their report, and on page 8 of which the following sentences appear in paragraph 20:

"In the past differentiation in incomes has been secured in part by variations in the fees charged by dentists. We have to recognise that this method of differentiation may not be permissible in a publicly organised service."

The state of affairs referred to has given rise to some measure of discontent in the profession, who however continue to accept the present system because of the difficulty of producing a practicable alternative which would be acceptable to the Government on the one side and to the profession on the other.

The Position of Practitioners of Advanced Years

102. The Association have been asked to give particulars of financial stringency suffered by any classes of dentists, illustrated by personal budgets of practitioners. It is regretted that this is not possible because personal budgets are not available although the Inland Revenue enquiry results may help in this respect as they did on the last occasion. It may be, however, that in their request for information as to the financial difficulties of particular classes of dentists, the Royal Commission have in mind the statistics quoted in paragraph 66 of the Report of the McNair Committee. Those figures, based on information secured from the Inland Revenue and direct from the profession in respect of the year 1952/53, showed that the average net income of dentists aged 55/64 years was only £950, and that the average net income of dentists aged 65 years and over was under £600. The figures quoted relate to England and Wales, but the graph on page 614 also depicts the position in Scotland. Clearly, many dentists in the two age groups had some difficulty in making a reasonable living, and although the position has improved to some extent following the abolition of the 10 per cent cut in May 1955 and the recent 2.6 per cent gross increase in fees, most older dentists have not been able for physical reasons to work for longer hours and so further improve their finances.

Factors Disturbing to the Profession

103. The remaining question asked by the Royal Commission which may be appropriately dealt with under this subsection is that concerning factors other than remuneration which affect the contentment of general dental practitioners. The McNair Committee have, of course, expressed their views on this question at some length and their Report indicates that on the information supplied to them, some of it by the British Dental Association, problems of remuneration are not the only causes of discontent. The Association dealt with this matter at some length in their memorandum in which they referred to the replies received from 1,687 practitioners to a questionnaire designed to assist the committee which was responsible for the preparation of the Memorandum to the McNair Committee. From the replies received to the questionnaire it became apparent that about two-thirds of the profession were not encouraging recruitment; amongst the reasons given for this attitude were cost of training, physical and mental strain of practice, insecurity of general dental practice in the National Health Service (arising from the possibility of arbitrary reduction of the scale of fees), interference with clinical freedom in National Health Service work, and finally, of course, reduced levels of remuneration resulting from *past* unilateral action by the Government. There is no point in quoting *in extenso* from the Memorandum, but the following two sentences are of particular importance as they really get to the root of the trouble:

"Dentists feel that it is entirely wrong that their financial position should be capable of being drastically altered for the worse by the mere stroke of a pen at the whim of the responsible Minister of whatever Party might be in power. A man can scarcely be expected to carry on his practice in the best possible manner and in the way most beneficial to his patients (and, incidentally, to the National Health Service) if his mind is continually troubled by what might almost be regarded as a 'sword of Damocles' perpetually poised over his head."

PART VII

REMUNERATION OF HEALTH CENTRE DENTAL OFFICERS

Ministry Insistence on Salaried Employment

104. The Association's Claim also covers dental officers in health centres, and although these are very few in number it is thought appropriate to refer to them next because they provide general dental services in the same way as do general dental practitioners working in their own surgeries. The difference between the two is that whereas private practitioners are remunerated by scale of fees, health centre dental officers are paid on a salaried basis by Local Executive Councils. There is no medical parallel to a health centre dental officer because doctors are allowed to rent surgeries in health centres and to treat patients in just the same way and under the same arrangements as if they were in practice in their own premises. Under the National Health Service Acts there is no reason why dentists should not be permitted to do likewise but the Ministry of Health and the Department of Health for Scotland have insisted as a matter of policy that health centre dentists are employed as salaried officers of Executive Councils.

Grades and Scales

105. There are three grades of health centre appointments, but it is understood that no appointments in Grade III (the lowest grade) have been made. There are now in England and Wales six dental officers on the Grade II health centre scale and seven on Grade I and the little improvement in the financial position of health centre dental officers since 1948 is made apparent by the comparative salary figures given below:

	1948	1953	1957
Grade II	£900 × £35 to £1,500 p.a.	£1,200 × £50 to £1,500 p.a.	£1,260 × £52 10s. 0d. to £1,575 p.a.
Grade I	£1,400 × £50 to £2,000 p.a.	£1,500 × £50 to £2,000 p.a.	£1,575 × £52 10s. 0d. to £2,100 p.a.

106. It may be desirable to mention here that the concern felt with regard to the salary levels of health centre dental officers was so great that, shortly before a claim in respect of all National Health Service dentists was submitted to the Ministry of Health, an independent claim was lodged in the hope that health centre dental officers would receive *ad hoc* consideration, i.e. apart from that given to their case in conjunction with other health service dentists based on the fall in the value of money. This claim has now been rejected on the grounds that the position of Health Centre Dental Officers will be considered by the Royal Commission, whose report must be awaited.

Parity in Medical and Dental Remuneration

107. There is one other aspect of the health centre service which is worthy of consideration. There is no hard and fast criterion by which candidates for health centre appointments are selected for Grade I or Grade II positions. Executive Councils have authority to appoint in any grade subject to approval by the Ministry of Health. In general, Grade I appointments are intended for dentists with not less than ten years' experience in practice and with the ability to carry out fairly advanced forms of treatment but some Executive Councils, London being the most notable example, have found it necessary in order to secure staff to make Grade I appointments only, there having been no candidates forthcoming for Grade II vacancies. The reason is obvious—the unattractiveness of Grade II remuneration.

108. Finally, it must be made clear that health centre dental officers do not have to meet expenses in the same way as do dentists in general practice, but nevertheless they carry out precisely comparable work and the Association consider that it is only

fair and reasonable that their net remuneration should likewise be comparable, making due allowance for the upward revision of general dental practitioners remuneration which is sought by the Association and which it is hoped will ultimately be achieved.

PART VIII

REMUNERATION OF HOSPITAL DENTAL CONSULTANTS AND SPECIALISTS, SENIOR HOSPITAL DENTAL OFFICERS, DENTISTS IN TRAINEE GRADES, AND GENERAL DENTAL SURGEONS

SECTION I—HOSPITAL DENTAL CONSULTANTS AND SPECIALISTS, SENIOR HOSPITAL DENTAL OFFICERS AND DENTISTS IN TRAINEE GRADES

Appointments by Executive Councils

109. The Spens Dental Committee recommended that dental specialists with comparable training and comparable qualifications to those of medical specialists should be remunerated within the same range, thereby reaffirming a principle which had been the rule in the wartime Emergency Medical Service. The Government's acceptance of this recommendation was implemented in June 1949 with the publication of "Terms and Conditions of Service of Hospital Medical and Dental Staff," whereunder the remuneration and terms of service of hospital dental consultants and specialists, senior hospital dental officers, and dentists graded as junior or senior registrars and house or senior house officers (these being the trainee grades for senior hospital dental officer and consultant appointments) were exactly parallel to those of their medical counterparts. Although since 1949 there have been occasions when, because of separate negotiating channels, the terms for the dental profession have temporarily compared unfavourably with those for the medical profession, all such disparities have been of relatively short duration and every material change in the medical terms has eventually been reflected in the dental terms with retrospective effect. At the present time hospital dental consultants and specialists and the other grades of hospital dentists referred to above are in all material respects on precisely the same footing as their medical colleagues.

110. It is, in the view of the British Dental Association, entirely right and proper that the two professions should march together so far as their terms and conditions of service are concerned. The knowledge and responsibility required of a dental specialist and of a medical specialist are entirely comparable and a dental specialist's work compares in importance and skill with that associated with many of the medical specialists. Just as in skill and responsibility the same high standards are required of both professions, so are the requirements in the way of training, qualifications, and experience precisely comparable. The would-be dental consultant, having first obtained his basic qualifications in dentistry, must progress through the same stages as his medical counterpart (house officer, senior house officer, registrar, and senior registrar) and must acquire a higher qualification before he can aspire to a senior appointment. The method of appointment to dental posts is exactly the same as that applicable to medical posts, i.e. advertisement and final selection by an officially constituted committee.

Prospect of Future Joint Negotiations

111. The fact that the terms and conditions governing the two professions have in the past been negotiated through separate channels has been touched on above. To bring the story up to date, it must be mentioned that negotiations for hospital dental consultants to be represented on the Joint Consultants Committee and on the Staff Side of Committee B of the Medical Whitley Council have reached an advanced stage. The object of this proposal, which has been accepted in principle by both professions and is under consideration by the Management Side of the Committee B, is to secure that negotiations on behalf of medical and dental consultants and doctors and dentists in the junior grades mentioned above shall in future be conducted through a single channel and to avoid repetition of the doubts and difficulties which arose in the past when the normal parity was temporarily disturbed. Being agreed on a principle of common negotiating machinery for the medical and dental

professions in the hospital service, the Association support fully the evidence to be given to the Royal Commission by the Joint Consultants Committee. They ask the Royal Commission to accept that evidence as being in all material respects applicable equally to hospital dental consultants, senior hospital dental officers and dentists in trainee grades.

Insufficiency of Consultant Posts

112. There are, however, certain additional considerations in so far as dentists are concerned to which the Association wish to draw the attention of the Royal Commission. In the Report of the McNair Committee reference is made in paragraph 73 to a Memorandum issued by the Ministry of Health in 1950 in which the view was expressed that the hospital service should provide a wider range of dental care of in-patients, that one whole-time dental surgeon should be available for each 500 beds to ensure adequate dental care for all patients, and that a dental surgeon specialising in oral surgery should be available in a large centre or for a group of smaller centres. One such consultant working whole-time was visualised as meeting the needs of a population of about 300,000. The McNair Committee commented that provision on this scale had not been reached and recommended that the number of consultant posts should, as soon as possible, be increased to the extent advocated by the Ministry of Health.

Frustration of Dentists in Trainee Grades

113. It is appreciated that it is not part of the Royal Commission's duty to consider the hospital dental service except in so far as remuneration is involved and it is with this last point in mind that the Association have drawn attention to the dearth of consultant posts which still obtains despite the McNair Committee's recommendations. The point is that inadequacy in numbers of dental consultant posts and mis-employment of senior hospital dental officers on consultant work, of which there is evidence in some areas, combine to frustrate and discourage hospital dentists in the trainee grades who, although having the same responsibilities as their medical colleagues, have prospects of ultimate attainment of consultant status which are disproportionately less, even allowing for the necessarily greater numerical strength of doctors at all levels of employment. Furthermore, because of inadequate consultant establishments, there are fewer opportunities of obtaining a distinction award. If the lack of opportunity for advancement continues, the hospital dental trainee grades will become in effect career grades, constituting for dentists therein a "blind alley" in the matter of status despite the undoubted likelihood of work of increasing responsibility and without consultant cover being undertaken by those concerned. The position can be rectified if the McNair Committee's recommendations are adopted and all hospital dentists carrying out work required of a consultant are given appropriate status and remuneration.

SECTION II—HOSPITAL GENERAL DENTAL SURGEONS

Inadequacy of Scales for Full-time Officers

114. The foregoing observations relate to the grades of consultant senior hospital dental officer, senior registrar, registrar and house officer. There is, however, a further grade, namely that of general dental surgeon, for which there is no precisely corresponding medical appointment. Disregarding for the moment the recent "interim award" of 5 per cent, the present salary scale (£1,000 × £50—£1,700) for full-time appointments in this grade was fixed by the Ministry of Health in July 1955. The fact that negotiations were concluded does not mean that the Association were satisfied with the position; they could not be so because this is another instance in which, unsatisfactory though the incomes of general dental practitioners working in their own surgeries may be, the position of their fellows providing general dental services in hospitals is very much worse. Bearing in mind all the relative points which have been made in other parts of the memorandum, it is clear that they are in a particularly unfavourable position financially and that substantial improvement is long overdue.

Inadequacy of Sessional Fees for Part-time General Dental Surgeons

115. The number of *full-time* general dental surgeons in hospitals is very small, but there are several hundred general dental practitioners normally working in their own surgeries who also give *part-time* service in hospitals on a sessional basis. Again disregarding the recent "interim award," the rate for these part-time appointments has remained unchanged since the earliest days of the Health Service at £150 per annum per weekly "half-day" of 3½ hours. This rate is quite inadequate by whatever standard it is measured. The original scale of fees on the basis of which dentists entered the general dental services was calculated to provide a gross income of something in the neighbourhood of £2 10s. 0d. an hour or about £8 15s. 0d. for 3½ hours, of which between £4 and £5 represents practice expenses. The rate of £150 per annum works out at less than £3 for a 3½-hour session. It must be remembered that most of the dentist's practice expenses continue while he is away from his surgery discharging his hospital commitments. It is, in fact, doubtful whether the return covers practice expenses; it is certain that it provides no margin for a man young enough to be able to catch up on time by working long hours at his surgery let alone a man of advanced years who, because of increasing physical strain, has to restrict his working time. It is clear from what has been said above that the rate was inadequate in 1948; it is even plainer that it is grossly inadequate at the present time bearing in mind diminishing money values since that year. It may be that in time to come conditions in the hospital dental service will have so improved that part-time employment for one or two sessions only will be a rarity but until that time arrives reliance will undoubtedly continue to be placed upon the help which can be given by part-time hospital general dental surgeons, irrespective of the number of sessions worked, and the Association consider that these dentists have an unanswerable case for a very substantial increase in remuneration.

PART IX

REMUNERATION OF LOCAL AUTHORITY DENTAL OFFICERS

Priority Classes Dental Service—History

116. The Association are aware that it is not regarded as being within the remit of the Royal Commission to make recommendations with regard to the remuneration of local authority dental officers, although this is a circumstance which the Association consider to be distinctly unfortunate. They understand, however, that there is nothing to prevent the Commission giving consideration to the position of local authority dental officers, who are engaged for the whole of their time in providing a dental service as part of a health service for the priority classes, i.e. expectant and nursing mothers, pre-school children, and, on present estimates, some 7,750,000 children attending maintained schools in England, Wales and Scotland.

117. Although certain dental services were provided by such agencies as the Boards of Guardians, largely at the instigation of the B.D.A., before 1900, the School Dental Services as known today originated as part of the School Medical Service by virtue of the Education Act 1907. The School Dental Service continues to be part of the School Health Service administered by local education authorities under the Education Acts, the most recent being the Act of 1953. The Maternity and Child Welfare Act 1918 empowered local authorities to provide dental treatment for expectant and nursing mothers and children under school age, such provision becoming an obligation by the National Health Service Act 1946. These combined dental services of Local Authorities constitute the priority classes dental services in the provision of which the dentists to which this Part refers are engaged.

Nature of Work of Local Authority Dental Officers

118. Local authority dental officers do not provide general dental treatment for the same ranges of the population as do general dental practitioners in the National Health Service or hospital general dental surgeons. Their work is comparable, however, as they are required to furnish full dental care for school children, and,

as explained, for younger children and expectant and nursing mothers: in any event, the day-to-day treatment of children in the higher age groups is in general similar to that provided for young adults and differs mainly from that for older people in the relatively infrequency of provision of dentures.

Dental Whitley Council (Local Authorities)

119. There are at present 947 full-time salaried dental officers employed by local health and education authorities in England and Wales, and 165 similarly employed in Scotland. Until the constitution in 1950 of the Dental Whitley Council (Local Authorities) as one of the Whitley Councils for the Health Services (Great Britain), the remuneration of these dental officers was entirely at the discretion of their employing authorities, and in view of the low salaries being generally offered, there was a considerable drift of dental officers to other branches of the National Health Service between 1948 and 1951, which reached such dimensions as to cause grave public concern for the dental health of the children. The first agreement made by the Dental Whitley Council, the Staff Side of which consists entirely of representatives of the British Dental Association, operated from October, 1950, and equated the scales of dental officers employed by local authorities on a national basis. The new scales, however, were insufficient to secure the restoration of the service to its previous strength, let alone produce the additional personnel needed to cope with the requirements of growing school population. Arbitration in the Industrial Court in 1954 resulted in further improvements and another agreement between Management and Staff Sides in April, 1956, further increased the scales in common with other increases being agreed for various groups of local Government officers. So that the effects of the changes may be readily appreciated, the scales operative at the various times are shown below:

	October 1950	January 1954	April 1956
Dental Officers ...	£800 × £50 to £1,250	£900 × £50 to £1,250 × £75 to £1,400	£1,000 × £50 to £1,350 × £75 to £1,575
Area Dental Officers ...	—	£1,450 to £1,500	£1,625 to £1,675
Chief Dental Officers ...	£1,250 × £50 to £1,550	£1,550 × £50 to £1,850	£1,725 × £50 to £2,025

Chief Dental Officers' scales vary according to the population ranges, but within the limits shown, up to a population figure of 600,000, above which the remuneration of Chief Dental Officers is at the discretion of employing authorities and it is a matter of regret and concern that this discretion is exercised somewhat ungenerously by some of the largest authorities with populations exceeding 1,000,000.

Negotiation Problems

120. The British Dental Association have played their part as Staff Side in the Dental Whitley Council (Local Authorities) and have honoured any agreements or awards duly made and do not therefore proffer criticism of relationships in existence with the Local Authorities. It will be appreciated, however, that there are great complications and difficulties involved in having to deal with the remuneration of an important branch of the health service apart from the majority of the profession and with Authorities which are at all times greatly concerned with the remuneration structure of the local Government services as a whole.

Strain of Continual Work on Children

121. The Ministries of Education and of Health have recommended to Local Authorities that dental officers can reasonably be expected to work on the basis of a three-hour chairside session each half-day. The practice of public dentistry naturally requires a certain amount of non-chairside time and it must be borne in mind that continual working on the mouths of children is a task which is among the most harassing of the many difficult and nerve-sapping tasks which a dentist is called upon to perform. What was said by the Spens Committee concerning the

strain of work "for the most part upon a conscious and apprehensive patient" undoubtedly applies with extra force in circumstances where the patients are children.

Status and Need for Autonomy of Dental Service

122. The title "Chief" or "Principal School Dental Officer" unfortunately does not signify that this officer is of Chief Officer status in the local government service because the post is that of a subordinate sectional head on the staff of the Medical Officer of Health and/or Principal School Medical Officer to each local authority. Dentists engaged in local authority work, therefore, labour under the handicap that they cannot hope to achieve the status and remuneration of a chief officer, unlike their colleagues in other professions, e.g. lawyers, accountants, architects, doctors, engineers, education officers, etc. This is a point which did not escape the notice of the McNair Committee for in paragraph 39 of their Report they refer to the fact that under many authorities dentists are regarded as being part of the staff controlled by the medical officer of health without distinction, so that the chief dental officer cannot be said to have complete control of the dental members of the staff. The McNair Committee went on to say that "there seems no justification for denying to the Principal dental officer control and freedom in dental matters and direct and independent access to the appropriate committees." The Association have indeed urged the need for autonomy of the local authority dental services upon the appropriate Government Departments on more than one occasion and it is still their view that autonomy is necessary in the interests of the officers concerned, and the services of which they are part.

Observations of the Guillebaud Committee

123. It is of significance that the Committee of Enquiry into the cost of the National Health Service (the Guillebaud Committee) gave some attention to the problem of the remuneration of local authority dental officers and the following paragraph (538) of their Report is self-explanatory:

"Para. 538—One lesson to be learnt from these last seven years is that if the local authority services and the general dental service are to be developed in step, then it is essential that the relationship between the two types of remuneration should be kept in balance. We appreciate that this is not a simple matter, as earnings in the general dental services apart from depending on the circumstances and capabilities of the individual practitioner, will fluctuate in accordance with the demands made on the service and these in turn will be affected by the incidence of charges."

The Association have long contended that local authority dental officers should be remunerated on the basis that they are dentists, with all the implications attendant upon engagement in the profession of dentistry, rather than as local Government officers as such. The Association are still of that opinion and trust that bearing in mind the dental background which they have been at pains to explain in detail the Royal Commission will see fit to stress the need for the priority classes dental services to be recognized as such, by employment therein being made financially attractive; this would constitute a reversal of the present position, for it can scarcely be denied that local authority dental officers are hopelessly underpaid.

Dentists Working on Sessional Basis for Local Authorities

124. What has been said previously applies to full-time Local Authority Dental Officers, but it must not be forgotten that general dental practitioners carry out sessional work in school and maternity and child welfare clinics in the same way as they do in hospitals. 567 dentists are so engaged in England and Wales, and 14 in Scotland: between them they represent the equivalent of 179 full-time officers, so the value of their services is self-evident. The sessional fees paid vary from one authority to another, but the average, on the most recent evidence available from enquiries made of Principal School Dental Officers, is about £3 3s. 0d. for a session of three hours, which, allowing for holidays works out at approximately

£150 per annum. The considerations bearing on the financial position of dentists absenting themselves from their surgeries to carry out sessional work have already been fully explained in paragraph 115, and the place where the sessional work is performed is immaterial. In the circumstances, practitioners helping to ease the man-power shortage in school and kindred clinics by carrying out sessional work clearly have as sound a case for a substantial improvement in remuneration as have their colleagues similarly employed in hospitals.

PART X

THE FUTURE

Scope of Proposals

125. The Royal Commission have asked the Association to submit specific proposals for dental remuneration in the future and also proposals for machinery or procedures to be established for dealing with future discussions of dental remuneration. In both these respects the Association welcome the opportunity to submit their ideas and with regard to the question of remuneration as such they wish to make it clear that their ideas are not confined to a 24 per cent increase in the level of net remuneration of general dental practitioners and other dentists in the National Health Service. This is not to say that they do not believe that there was and still is justification for an increase of at least that order bearing in mind the fall in the value of money between April 1951 and April 1956, but it is now their hope that financial improvement not necessarily related in this instance entirely to the value of money will be advocated by the Commission. The Association also hope that when the Royal Commission come to assess the needs of the situation they will be in no doubt, by virtue of the exposition of the dental background which comprises the first section of this Memorandum, as to the nature of dentistry and its value to the community, the qualifications which are a prerequisite to the practice of dentistry and the time, labour and expense involved in obtaining them, and the shortage of dental man-power which will be accentuated within a few years and which makes a marked impetus in dental recruitment a matter of top priority.

Influential Factors

126. Finally, before the Association's views as to what should be the immediate levels of remuneration are expressed, it may be helpful if points of consequence which have a bearing on the situation and deserve consideration in relation to the Association's claim are now made the subject of brief reference although each point has been dealt with in detail earlier in this document. The points in question are as follows:

- (i) The Spens Dental Committee, like the Spens Medical Committee, left it "to others" to translate to post-war money values the financial recommendations which they made in terms of pre-war money values. This translation was undertaken by the Government, whose representatives, during the talks preceding the introduction of the 1948 Scale of Fees, gave the profession's negotiators to understand that medical and dental betterment would be the same: clearly this was in accordance with the intentions of the Spens Committee, as explained in the letter from their Chairman quoted in paragraph 61. What happened in practice was that the first dental scale allowed for 20 per cent betterment, which did not simply disappear but was replaced by what might justifiably be described as a 20 per cent deterrent from June 1949, on which date was introduced a new Scale with gross fees cut overall by 20 per cent, equivalent to a net cut of about 40 per cent. Further, from May 1950 to May 1955 there was the additional infliction of the 10 per cent cut in gross fees, equivalent to 20 per cent on net incomes. In contrast, medical payments were never cut, but indeed by the adjudication of Mr. Justice Danckwerts were substantially improved inasmuch as betterment was raised to 85 per cent from 1948 and 100 per cent from 1951.

- (ii) It may be suggested that in order to make a proper comparison between medical and dental remuneration regard should be had to the comparable recommendations of the Spens Committee, i.e. the "income levels" recommendations. This argument does not stand up to examination, as the income levels recommendation in the case of dentists was intended to apply only when there were sufficient dentists in relation to the demand for their services. In saying that that situation does not obtain, the Association do not merely express an opinion, but state a proved fact, *vide* the Report of the McNair and Guillebaud Committees. It is clear, therefore, that the second of the Spens Dental Committee's recommendations—the "basic income" recommendation—is the one which is relevant. That recommendation was a special remedy designed to meet the needs of a special situation, and so long as that situation remains unaltered so should single-handed dentists, fulfilling the conditions specified in the recommendations, be able to earn for 1,500 hours' chairside work, a net income of £1,600 plus appropriate betterment.
- (iii) The fact that since the inception of the National Health Service the majority of dentists have worked longer hours in order to meet the public demand than those advocated by the Spens Dental Committee does not constitute evidence that the Committee's conclusions were wrong; even if that were so there is clearly a very definite limit beyond which continued work by a dental practitioner is calculated to undermine his health and eventually disrupt or curtail the service he can give to his patients.
- (iv) The Spens Dental Committee visualised that incomes in advance of those which they regarded as standard could be earned by practitioners in partnership or employing assistants: that has happened, but is a circumstance which is not in any way discreditable to the dental profession nor an indication of anything except that labour above normal will produce earnings above normal.
- (v) The net incomes of single-handed general dental practitioners have shown improvement in recent years, but this is due entirely to a considerable increase in the amount of work performed. After the recent 2.6 per cent gross increase a single-handed practitioner's estimated *basic* net income is only £1,087.
- (vi) To have regard to earnings without taking into consideration the hours of work involved would be tantamount to adopting the view that dentists are only entitled to reasonable incomes if they work overtime.
- (vii) If proof of the contentions made in (v) is needed it is provided by the various Regulations which have introduced cuts in gross fees: the plain fact is that gross fees are in 1957, even after allowing for the 2.6 per cent increase from May 1st, 17.9 per cent below what they were in 1948 and the corresponding disparity in the rate of net remuneration is about 39 per cent, a situation which must be unique in any profession, occupation, trade, or industry.

The Advocated Basic Net Income

127. With the background fully explained, the Association trust that the Royal Commission will be disposed to support the opinion of the Association that the remuneration of general dental practitioners in the National Health Service should be increased by the institution of a scale of fees designed to produce for the hours of work recommended by the Spens Committee £3,200 net per annum less 8 per cent representing the Government Superannuation contribution, giving approximately £2,950 per annum. (£3,200 represents an addition of 100 per cent to the Spens 1939 money values figure of £1,600, and is considered to be a very reasonable and indeed a minimal requirement, in view of the fact that price levels in 1957 are 171 per cent above those obtaining in 1938, and that general salaries in ranges above £1,000 in 1936/37 had at least doubled by 1954/55 (see "Changes in the Distribution of Higher Incomes"—Professor R. G. D. Allen, "Economica," May 1957.) The figure of £2,950 would not necessarily prove to be the average net income of general

dental practitioners if a scale on the suggested lines were introduced. A man who was not able to work at the speeds regarded as reasonable by the Penman Committee would automatically receive a lower net income unless he worked at the chairside for more than 33 hours per week; on the other hand men who are able to work efficiently at a higher tempo per operation than envisaged by the Penman Committee would automatically earn more than £2,950 in a year, unless they reduced their hours of work to below 33. The Association suggest, however, that these are not circumstances which should be allowed to detract from the argument in favour of the introduction of a fair and reasonable basic scale of fees. The Association of course appreciate that the Royal Commission are concerned only with net remuneration and that being so they do wish to emphasise that, after the Commission's ideas as to net incomes are made known, the formidable task of formulating a scale of gross fees will have to be undertaken by the Association and the Ministry of Health. Some idea of the difficulties involved in this task may be obtained when it is mentioned that the negotiations following the 1955 Agreement took two years, during which period dentists' expenses and the cost of living continued to rise. In view of the inevitable delay occasioned by negotiations on gross fees, the Association also hope that the Royal Commission will be disposed to advocate as an immediate interim measure, a percentage increase in net remuneration.

128. So far as dentists in other fields of employment are concerned the position is somewhat different inasmuch as some are paid on a salary basis and others on a sessional basis, but the difference is not so marked since, as mentioned earlier, in the part relating to the local authority dental services, dentists should be remunerated as dentists. The position would, therefore, be met, the Association consider, by the introduction in the health centre and local authority spheres of scales with maxima commensurate with the proposed net level for general dental practitioners, and with appropriate increases for area and chief dental officers in the one case and Grade I health centre dental officers in the other case. Such a scale could also be appropriately applied to general dental surgeons in the hospitals, but the remuneration of practitioners working on a sessional basis in hospitals or clinics should be proportionate to the gross income basis of the general dental services scale of fees designed to produce a net income of £2,950 per annum. With regard to hospital dental consultants and specialists, senior hospital dental officers, and dentists in trainee grades, as has already been explained in the Part relating to hospital dental work what is sought is continuation of parity in remuneration with doctors holding comparable hospital posts.

Need for Arbitration Machinery

129. The remaining matter, and it is one of importance, which requires to be dealt with is that of machinery for dealing with dental remuneration in the future. There have been quoted in this Memorandum in paragraph 48 two sentences from the Association's memorandum to the McNair Committee giving reasons for the profession's sense of insecurity in relation to general dental practice in the National Health Service. The profession's fears have been more than justified because whereas in industry, in trade, in a good many professions, and in the Civil Service the avenue of arbitration is open, that avenue is closed to professions in the Health Service. In theory, the profession can resort to arbitration through the Industrial Court, but that is in theory only, as following the award of Mr. Justice Danckwerts to the medical profession in 1951, the Chancellor of the Exchequer stated quite categorically in the House of Commons that the Government did not again propose to place Parliament in the position of having to incur expenditure of millions of pounds of public money because of the decision of someone outside Parliamentary control. This means that to general dental practitioners in the National Health Service, and indeed to general medical practitioners, and members of other professions similarly engaged, their paymaster, the State, seeks to be the sole arbiter in connexion with any dispute which may arise. **The British Dental Association consider that this position is absolutely wrong and that dental surgeons should at least be given the same rights and privileges as those given to most classes of employed persons including the bulk of the Civil Service.**

130. What is required is arbitration machinery to which the profession may resort as of right in the event of a breakdown in negotiations on terms and conditions of service, and the Association consider that the case would be met by the appointment of an independent arbitrator, acceptable to the profession, who would officiate, with the aid of two assessors, in disputes between the Government and the British Dental Association. So far as the assessors are concerned, one should be appointed by the Ministry of Health, and one by the Association, the only organisation representative of all dental practitioners engaged in work under the National Health Service.

131. Whether or not the view expressed in the last paragraph be fully accepted by the Royal Commission, the Association earnestly hope that by reason of the third of their terms of reference the Commission will recommend that there be instituted, for the purposes of keeping under review the remuneration of National Health Service dentists, arrangements which will not merely be of convenience to whatever Government be in power but will be fully acceptable to the profession themselves.

Explanatory note by the Royal Commission

On 12th February, 1957, the British Dental Association submitted to the Minister of Health and the Secretary of State for Scotland a claim for increases in the remuneration of hospital dental officers, health centre dental officers and general dental practitioners in the National Health Service.

A copy of this claim was sent by the Association to the Royal Commission. It was submitted solely for the Commission's information and did not form a part of the Association's direct evidence to the Commission.

As references to the claim were made during oral proceedings it is thought the document might conveniently be published in this volume. The Association's claim and covering letter to the Minister of Health are therefore reproduced in the following pages.

BRITISH DENTAL ASSOCIATION

12th February, 1957.

The Rt. Hon. D. F. Vosper, T.D., B.A., M.P., Minister of Health,
Savile Row, London, W.1.

SIR,

On 28th March, 1956, a letter was sent to Mr. Turton informing him of the intention of the British Dental Association to submit, in the near future, a claim for increases in the remuneration of hospital dental officers, health centre dental officers and general dental practitioners in the National Health Service to offset the fall in the value of money since 1950.

The Association have delayed until now the submission of their claim for two reasons: firstly, they have been mindful of the general economic situation and of other matters of national and international importance which have engaged the Government's attention, and secondly, they have been anxious that the revision of the 1949 Scale of Fees, in accordance with the agreement made with Mr. MacLeod in the Spring of 1955, should be completed. This revision, which it must be emphasised is designed to adjust relative fees for various items and not to increase the remuneration derived from a given amount of work, is now almost an accomplished fact and whatever be the economic position, various professional and higher salaried groups have been awarded increased remuneration and others have claims which are pending. The British Dental Association would, therefore, lay themselves open to justifiable criticism by their members if they were further to delay the submission of their claim.

The claim, which accompanies this letter, and which actually seeks to offset the fall in the value of money since April, 1951, is presented in some detail and is self-explanatory. It is pertinent to point out, however, that the vast majority of those who will derive financial benefit if the claim is conceded are general dental practitioners, special reference to whom is made because they are remunerated in accordance with a scale of gross fees, whereas the claim is for an increase of 24 per cent in net remuneration. Bearing in mind the heavy reduction in gross fees effected since the dental profession entered the National Health Service in 1948, the claim must surely be regarded as being extremely reasonable.

The Association consider that the urgency of the need for consideration of the present claim is reinforced by the Report of the McNair Committee. As your predecessor was recently informed, the Association intend to submit a Memorandum with reference to paragraphs 121/123 of the Report, the first two of which envisage a review of dental remuneration. What form the Memorandum will take is, as yet, uncertain, but it can be said that it will not deal with the specific cost of living issue which is now raised and which forms the whole basis of the present claim.

A letter in similar terms is being sent to the Secretary of State for Scotland.

I am, Sir,

Your obedient Servant,

H. PARKER BUCHANAN,
Secretary.

BRITISH DENTAL ASSOCIATION

REMUNERATION OF GENERAL DENTAL PRACTITIONERS, HOSPITAL
AND HEALTH CENTRE DENTAL OFFICERS

INTRODUCTION

A. General Dental Practitioners in the National Health Service

1. The remuneration of general dental practitioners in the National Health Service has been governed or affected by legislation or regulations as under:—

- (a) July 5, 1948—Inception of National Health Service.
- (b) July 5, 1948—National Health Service (General Dental Services) Fees Regulations, 1948.
- (c) Feb. 1, 1949—National Health Service (General Dental Services) Fees (Amendment No. 2) Regulations, 1949.
- (d) June 1, 1949—National Health Service (General Dental Services) Amendment (No. 2) Regulations, 1949.
(Cancelled (c): reduced Scale under (b) by approximately 20 per cent).
- (e) May 1, 1950—National Health Service (General Dental Services) Fees (Amendment) Regulations, 1950.
(Imposed 10 per cent cut).
- (f) May 10, 1951—National Health Service Act, 1951.
(Authorised charges for dentures).
- (g) May 22, 1952—National Health Service Act, 1952.
(Authorised charges for treatment).
- (h) June 15, 1954—National Health Service (General Dental Services) Regulations, 1954.
(Consolidated previous N.H.S. Regulations including (d)).
- (i) May 1, 1955—National Health Service (General Dental Services) Amendment Regulations, 1955.
(Cancelled the 10 per cent cut).

2. The original (1948) Scale of Fees although not wholly agreed between the Ministry and the three dental organisations then existing was framed with the intention of giving effect to the recommendations of the Interdepartmental Committee on the Remuneration of General Dental Practitioners (Chairman, Sir Will Spens). The remit of that Committee had been to consider what ought to be the range of total professional income of a registered dental practitioner in any publicly organised service of general dental practice: to consider this with due regard to what had been the normal financial expectations of general dental practice in the past, and to the desirability of maintaining in the future the proper social and economic status of general dental practice and its power to attract a suitable type of recruit to the profession: and to make recommendations.

3. In their Report which, like its medical counterpart, was accepted in principle by the Government of the day, the Committee said, *inter alia*, that a single-handed dentist working 33 chairside hours a week plus non-chairside hours, reckoned to be about nine per week, should receive in 1939 money values a net annual income of £1,600. The Committee also expressed the view that it was legitimate to compare an income of £1,600 in the case of such a single-handed dental practitioner with an income of £1,800 in the case of a general medical practitioner working from 50 to 55 hours per week; in that assessment due allowance was made for the "intensive strain" of a dentist's chairside work.

4. The Spens Dental Committee, like their fore-runners the Spens Medical Committee (under the same Chairmanship), left "to others" the problem of the adjustment of pre-war incomes to take into consideration post-war conditions but observed that adjustment should have direct regard not only to estimates of the change in

the value of money but to increases which had taken place since 1939 in incomes in other professions. They also expressed the opinion that it was only if corresponding changes were made in the incomes of general dental practitioners that the recruitment and status of their profession would be maintained.

5. The adjustment of incomes contemplated by the two Spens Committees has become known to the medical and dental professions as "betterment", and in the case of dentists betterment was arbitrarily determined by the Ministry of Health as 20 per cent on the Spens advocated net income figure for a single-handed practitioner of £1,600. The dental profession's negotiators were informed at the time (May, 1948) that the percentage was the same as that applied in the case of general medical practitioners, and were assured that if the doctors succeeded in obtaining a higher betterment factor, the dentists would get the same. It became apparent, however, from the evidence presented to Mr. Justice Danckwerts during the arbitration hearing in respect of the remuneration of general medical practitioners, that from the inception of the National Health Service medical betterment differed from dental betterment, and the disparity widened appreciably after the Arbitration Award had been put into effect.

6. The promise made to the dental profession's negotiators in 1948 has therefore not been kept, despite a categorical statement in a letter to the Ministry of Health from the Chairman of the Spens Committee, dated 14th July, 1948, that "the Dental Committee's Report was made on the assumption that both sets of recommendations would be subject to appropriate and *similar* betterment".

7. Dentists' incomes fell considerably from 1949 to 1952/53 as the result of reductions in the Scale of Fees and the introduction of charges for dentures and for treatment, and after examining the combined results of enquiries into the incomes and expenses of general dental practitioners in the National Health Service for 1952/53 (conducted by the Inland Revenue and by the British Dental Association) the Minister of Health agreed to cancel the 10 per cent cut with effect from 1st May, 1955, subject to certain conditions.

8. The Minister suggested, and the British Dental Association agreed, that as a full settlement of dental remuneration *at the present time* the revised Scale which was already under negotiation between his Department and the Association should be worked out on a basis that would produce for the same amount of work the incomes that would have been earned in the inquiry period had the 10 per cent reduction not then been in force.

9. Restoration of the 10 per cent meant in effect the re-introduction of the 1949 Scale (paragraph 1 (d) consolidated in (h)) and the revised scale still under negotiation will have approximately the same financial results. The position, therefore, is that the dental profession are back where they were in mid 1949, a state of affairs which is certainly an improvement on that which obtained a year ago but which has no regard to the marked fall in the value of money in recent years. The situation is that the income levels of general dental practitioners now approximate to those reached in 1949 but the monetary value of payments received has been sadly reduced.

10. At no time has it been suggested by the Association in their negotiations with the Ministry concerning the 10 per cent cut or the revised Scale that their object has been to secure an improvement because of the cost of living; it is therefore an entirely new issue which is now raised and which it is suggested should in all fairness receive serious consideration in the same way as have claims from other sections of the community for cost of living increases which have in fact been granted on many occasions since 1951 and indeed earlier than that.

B. HOSPITAL DENTAL OFFICERS

11. The Spens Dental Committee recommended that dental specialists with comparable training and comparable qualifications to those of medical specialists should be remunerated within the same range. In fact the remuneration of dentists in hospitals (other than general dental surgeons, to whom special reference will be made later) has been on a par with that of their medical counterparts from the

beginning of the National Health Service although on occasions when increases for medical officers have been agreed in Medical Whitley Committee B such increases have only been given to dental officers holding comparable posts after the submission of representations by the British Dental Association. The last increase given to hospital medical staffs purported to restore the relationship of their salaries to the remuneration of general medical practitioners which existed before the Award of Mr. Justice Danckwerts was made and to fulfil the intentions of the Spens Medical Committee. Whether those intentions were indeed fulfilled is a matter for argument but what cannot be denied is that the value of money has fallen to a marked extent since the date when the Danckwerts Award was made. Hospital dental officers are therefore suffering from the effects of inadequate betterment in the same way as their medical colleagues.

12. The foregoing comments apply to the grades of Consultant, Senior Hospital Dental Officer, Senior Registrar, Registrar and House Officer. There is a further grade, that of General Dental Surgeon, which calls for separate comment since there is no precisely comparable medical appointment. The present salary scale for full-time appointments in this grade was fixed by the Ministry of Health in July 1955 after negotiations with the Association. The remuneration for part-time appointments was fixed by the Ministry in 1949 and has remained unchanged in spite of continual representations by the Association as to its inadequacy. Clearly general dental surgeons are entitled to equal consideration in the matter of betterment with their colleagues practising on their own account under the National Health Service, and of course it follows that any betterment improvement in the case of other hospital dental officers would worsen the relative position of general dental surgeons unless they too were given the same consideration.

C. HEALTH CENTRE DENTAL OFFICERS

13. The remuneration of dental officers in health centres was originally determined by the National Health Service (General Dental Services) Fees (Amendment) Regulations, 1948 which came into operation on vesting day, i.e. 5th July, 1948. These fees were not regarded by the British Dental Association as being adequate and representations were made to the Ministry of Health as a result of which new regulations were introduced effective from 15th August, 1953. These regulations included improved scales of remuneration for dentists in the three health centre grades but the scales fell short of the proposals made by the Association to the Ministry.

14. The number of health centre dental officers is not large but that circumstance in no way affects the right of such officers to be remunerated at such rates as place them in a position reasonably comparable with that of their fellow practitioners engaged in other fields of dentistry. They feel the effect of increases in the cost of living in just the same way as not only other dentists, but indeed all other citizens and their case for improved remuneration to offset the fall in the value of money is equally good.

THE CASE

15. The case is a simple one; it rests on the fact that the purchasing power of the pound has declined since 1950 and it is supported by the further fact that salaries and earnings in other occupations have been and are being increased.

16. That purchasing power has fallen, and fallen progressively, in the post-war period is a fact beyond dispute. There have been only two short periods of relative stability, when prices, though still rising, were rising slowly. One of the periods was in 1948-49 before the devaluation of sterling; the other was in 1952-53. Otherwise prices have increased substantially year by year.

17. A measure of the fall in purchasing power is to be obtained from an index number showing the movements in retail prices. In a written answer to a question put by Mr. de Freitas (Hansard, 4th May, 1956), Sir E. Boyle gave 16s. 7d. as the purchasing power of the pound in March 1956, taking the value in October 1951 as 20s. This represents an increase of 20 per cent in retail prices, and implies that spendable income would need to be increased by 20 per cent to maintain purchasing

power, from October 1951 to March 1956. Since prices were increasing rapidly in 1951, the corresponding figure for the whole period since the end of 1950 is about 30 per cent.

18. The index used in these calculations (as noted by Sir E. Boyle) is the Ministry of Labour's Index of Retail Prices. The index, however, is of restricted coverage and weighted in a manner appropriate to working-class households; and there have been two changes in its compilation since 1950. For salaried and professional earners, it is preferable to take an index which relates to the whole range of consumers' expenditure, including such items as motoring, domestic service and insurance. Such an index is provided in the annual Blue Books on National Income and Expenditure:

Consumers' Expenditure : Index Numbers of Market Prices
(1948 = 100)

1948	100	1952	121.0
1949	102.4	1953	123.3
1950	105.8	1954	125.6
1951	114.5	1955	130.0

These index numbers are weighted with reference to the current pattern of consumers' expenditure each year and (as a technical matter) they are likely to understate, rather than to overstate, the upward movement in prices.

19. For reasons given later, a measure is required of the decline in purchasing power (or of the increase in prices) from 1st April, 1951 to April, 1956, a period of five years. If the Ministry of Labour index is used to interpolate and extend the annual figures above, the increase in prices is from 110.8 at 1st April, 1951 to 137.3 in April, 1956. Hence, in the period of five years from 1st April, 1951, there has been an increase in price of 24 per cent and a corresponding decline in the purchasing power of the £.

20. This is to be supplemented by measures of the rise in salaried and professional incomes since 1950. The Blue Books on National Income and Expenditure (with provisional figures for 1955) give the following aggregates:

Aggregate Annual Earnings
(£ mn.)

	Wages	Salaries	Self-employed professions
1951	5,080	2,575	226
1952	5,410	2,760	231
1953	5,745	2,895	241
1954	6,170	3,095	258
1955	6,690	3,330	272

The number of employees (wage and salary-earners) increased by about 3½ per cent in the four years 1951-55; but the number of self-employed professional people almost certainly did not increase and may well have declined. Further, the figures for the independent professions include, as a substantial constituent, the earnings of general medical and dental practitioners, increasing much less than the earnings of other professional people. It can be estimated that, in the four years from 1951 to 1955, earnings per head increased by 26-27 per cent for wage and salary earners; and by over 20 per cent for the independent professions or by nearly 25 per cent if medical and dental practitioners are excluded. The increases for the full period of five years from 1st April, 1951 are correspondingly greater.

21. These are very broad figures, relating to groups of great diversity of type and amounts of earnings. It is important to pay some attention to differentials between the lower and the higher-paid, to what can be termed the "concertina" effect. In the post-war period (as during the war), differentials were reduced, the

concertina squeezed up. As Dudley Seers shows (Bulletin of Oxford Institute of Statistics, Feb. 1956), the evidence is that, as early as 1954, there was some increase in the differentials, some opening up of the concertina, as between the more-skilled and the less-skilled wage earners. This process has continued and it has extended to salary earners since 1954. The opening up of the concertina is particularly evident in recent awards to such groups as school teachers and civil servants.

22. It is, indeed, especially relevant to consider the increases in pay of teachers and civil servants. They are representative of what has been happening recently to earnings in higher-paid and professional occupations; and they are two large groups for whom (as for the medical and dental professions) the government is the paymaster. The movement of salaries from 1948 to date in these groups is illustrated in the attached chart. Taking dates at which general and substantial revisions took place:

Administrative Class Civil Service					Per cent increase in salary		
					Oct. 1950 -Jan. 1953	Jan. 1953 -Apr. 1956	Oct. 1950 -Apr. 1956
Asst. Principal*	Min.	...	...	...	18	19	40
Principal*	Min.	...	...	...	15	11	27
Asst. Secretary	Min.	...	...	...	13	18	33
	Max.	...	...	...	10	18	30
Under Secretary	...	...	...	...	4	25	30
Deputy Secretary	...	...	...	...	—	31	31
Permanent Secretary	...	...	...	...	—	33	33

* Including Extra Duty Allowance (1950 and 1953), abolished 1956.

Teaching in Primary and Secondary Schools					Per cent increase in salary		
					Apr. 1951 -Apr. 1954	Apr. 1954 -Oct. 1956	Apr. 1951 -Oct. 1956
Basic minimum	...	...	...	...	20	6	27
Good Honours graduate	Min.	...	...	...	21	14	38
	Max.	...	...	...	17	26	48
Typical Head Teachers:							
Secondary modern	...	...	...	...	12	38	54
Secondary grammar	...	...	...	...	10	27	39

The selection of points on salary scales is made here with particular reference to the pay of graduates. (See Note 1.)

23. In a period of 5½ years from 1950-51 to 1956, these groups of teachers and higher civil servants have had pay increases of about 30 per cent or more. This is a greater rise than would be indicated by the decline in the purchasing power of money (24 per cent approximately). The extra rise may well be connected with the fact that the groups were under-paid in 1950-51. But, whatever the reason, it is clear that, as between these groups and many of the lower-paid occupations, the concertina has been opened up. Just as significant is the fact that, as between the higher and lower paid within each group, the concertina was closed in the

Note 1: For example, a graduate direct-entrant to the Administrative Class of the Civil Service passes through the Assistant Principal and Principal grades (for which the minima are shown) and almost certainly becomes an Assistant Secretary, at age about 40. He may not rise above this grade, so that both the minimum and maximum of Assistant Secretaries are shown. Further, though only the Administrative Class is shown, the pay in such classes as Statistician and Scientific Officer is similar and closely related.

first half of the period and then opened up again. The evidence is that, in the last few years, the pay in these two broad professional occupations has more than kept pace with rising prices, and particular attention is being paid to the remuneration of those in the higher ranks.

24. The conclusion, from the point of view of such professional occupations as the dentists, is that, at the very least, the decline in the purchasing power of the pound should be compensated by higher pay, the appropriate increase being 24 per cent. There is no longer any justification (indeed just the contrary) for squeezing these higher-paid and more responsible groups. (See Note 2.)

25. It remains to examine the position of each group of dentists to which the present claim relates, with particular reference to fixing the starting point for the application of the foregoing conclusion. As regards *general dental practitioners*, the bulk of their income is derived from schedule payments, which depend in part on the scale of fees in force and in part on the demand for dental services (and hence on the hours worked by dentists). The only change since 1950 in the scale of fees was the imposition of the 10 per cent cut from April, 1950 to April, 1955. If, for purposes of comparison, this 10 per cent cut is added back to annual payments, then the same scale of payment is applicable throughout and variation in earnings is due partly to variation in the nature of the work undertaken but in the main to hours worked:

Payments, Great Britain
Average per principal, £ per year

Period	Actual payment	Adjusted for 10 per cent cut	Corresponding net income*
<i>Statistical information obtained from the Ministry of Health—all practitioners, (i.e. whether single-handed, employing assistants or in partnership)</i>			
4/1949 to 3/1950	4,777	4,777	2,484
4/1950 to 3/1951	4,317	4,757	2,474
4/1951 to 3/1952	3,586	3,984	2,071
4/1952 to 3/1953	2,964	3,293	1,712
<i>Statistical information obtained by Inquiry through Inland Revenue and by questionnaire—all practitioners (i.e. whether single-handed, employing assistants or in partnership)</i>			
4/1952 to 3/1953	3,345	3,717	1,933
<i>(—single-handed practitioners only)</i>			
4/1952 to 3/1953	2,875	3,194	1,660
<i>Statistical information obtained from the Ministry of Health—all practitioners, (i.e. whether single-handed, employing assistants or in partnership)</i>			
4/1953 to 3/1954	3,143	3,492	1,816
4/1954 to 3/1955	3,428	3,809	1,981
4/1955 to 3/1956	4,047	4,084	2,123

* Deducting practice expenses as determined in the 1952-53 inquiry, i.e. 53½ per cent of the gross payment including 10 per cent cut, or 48 per cent (as taken here) of the gross payment with 10 per cent cut added back.

Note 2:—It is immaterial whether this correcting factor is applied to income before or after taxation. For incomes of about £2,000 rising in step with prices the various reductions in rates of income tax since 1950 are almost exactly offset by the progressive nature of income taxation and the proportion of income left after tax remains constant.

The effect of the imposition of charges is seen in the decline in schedule payments (which include amounts paid by patients) in 1952-53 and in the recovery from 1954.

26. The scale of dentists' fees has not changed, apart from the 10 per cent cut, and the amount of work done is now about the same as in 1951. In money terms, dentists' incomes are no higher now than in 1951 (if the cut had not then been in force) and the only change in between was for the worse. It can be maintained, without any doubt whatever, that the general dental practitioner has had no protection against the decline in the purchasing power of the pound at any time from 1st April, 1951 or indeed earlier.

27. Except during 1952-53, the year covered by an Inquiry into incomes and expenses, which was conducted with the co-operation of the Inland Revenue and by means of a questionnaire sent to general dental practitioners in the National Health Service, there is no evidence available as to the earnings of single-handed practitioners. It is reasonable, however, to assume that the same relationship between average earnings of all principals, and those of single-handed dentists, exists as in 1952-53 which means that during 1955-56 when the average earnings of all principals amounted to £4,084, single-handed earnings (gross) must have averaged £3,480. Applying the 48 per cent expenses ratio, the net income for a single-handed practitioner for 1955-56 only works out at an average of about £1,800, or £20 more than the net income which the original (1948) scale of fees was designed to produce for a single-handed practitioner working 1,500 chairside hours a year.

28. It is important to supplement this statement of the position by reference to the findings of the Spens Report (Cmd. 7402). The matter of hours is particularly relevant. The standard of efficiency envisaged in the Spens Report was translated into a usual practice of not over 1,500 chairside hours, or 1,900 hours in all, per year. The Report specifically recommended additional remuneration for those experienced practitioners who work more than 1,500 chairside hours a year without loss of efficiency, as well as for those with salaried assistants or under partnership agreements with junior partners. Hence, even if the purchasing power of the pound does not decline and incomes elsewhere do not rise, the Spens Report allowed for an increase in dentists' remuneration whenever single-handed dentists are required to work longer hours and whenever partnerships and practice with assistants increase.

29. According to the 1952-53 inquiry, single-handed dentists worked more than 2,100 hours a year. Even in that period of relatively low demand for dental services, dentists were working hours in excess of the Spens standard. The excess is considerably more now than in 1952-53. Even so, the net incomes now obtained by single-handed dentists are certainly not more, in comparison with the remuneration of general medical practitioners, than envisaged in the Spens Report. The conclusion here is that, despite more work, general dental practitioners are not earning more than the Spens Report thought they should, in relation to the remuneration of general medical practitioners determined as appropriate (in the Danckwerts award) to the year 1950-51. Again it is clear that there has been no allowance whatever for the decline in the purchasing power of the pound which has taken place since 1951.

30. As regards *hospital dental officers*, remuneration is related, as it must be, to that of medical staffs in hospitals. The award of 1954 set the salary scales of medical staffs, and hence of dental staffs, as from April, 1954. The basis of the award was that the balance of medical remuneration was disturbed by the Danckwerts award to general medical practitioners. The award brought the salaries of hospital staffs into line with the remuneration of general medical practitioners as determined (by Danckwerts) for 1950-51; it took no account of changes in betterment or in other incomes since March 1951. The present salary scales of hospital medical staffs, and hence equally of hospital dental staffs, do not allow for any such changes and the present claim is designed to correct this.

31. In the Introduction (Para. 12) reference is also made to general dental surgeons, both full-time and part-time. So far as full-time officers in this category are concerned the contention is that there should be an increase of 24 per cent in the scale fixed by the Ministry of Health in July, 1955 after negotiations with the B.D.A., that scale having superseded an earlier scale which was never at any time recognised by the Association. In the case of part-time officers, an increase

of 24 per cent in their remuneration on what are in effect cost of living grounds is likewise sought, the Association reserving their right to renew representations concerning the inadequacy of the existing payments for these appointments.

32. There are three Grades of *Health Centre appointments*, but it is understood that in actual fact no appointments in Grade III (the lowest Grade) have been made: in the case of Grades I and II the maxima of the Scales introduced in 1953 were the same as those of the Scales which operated at the commencement of the National Health Service. In the circumstances, in order not to complicate matters, and without prejudice to any negotiations for improvement of the 1953 scales, the present claim is taken as applying to the maxima of the Health Centre Dental Officer scales, with a consequential adjustment of salaries below the maxima.

33. It is the responsibility of government to protect the economic and social position of all those paid directly or indirectly out of government funds. This is essential if the efficiency, and the position as regards recruitment, of the groups concerned are to be ensured. Moreover, the government is not only the paymaster but also, in its other function as the monetary authority, it is responsible for any decline in the purchasing power of money which may occur. It is not a wise policy to attempt to provide health services "on the cheap" by progressively underpaying doctors or dentists. The present remuneration of dentists, in general practice and in hospitals alike, takes no account of changes since March, 1951, either in the purchasing power of the pound or in pay in other occupations. Prices in April, 1956, were 24 per cent higher than at 1st April, 1951, and the evidence provided by recent revisions in pay (e.g. for civil servants and teachers) is that the concertina-like squeeze on higher incomes is being relaxed. This should apply to dentists as to others in responsible positions.

THE CLAIM

34. The Claim is, therefore, that the net remuneration of general dental practitioners, and the salaries of hospital dental officers should be increased by at least 24 per cent to offset the decline in purchasing power between 1st April, 1951, and April, 1956; that the maximum salaries of the Health Centre Dental Officer grades be increased by a similar percentage with appropriate adjustment of salaries below the maxima; and that all increases should date from April, 1956.

35. The Claim may be summarised as a request for the implementation of obligations which have been in existence since 1948, and for an adjustment in remuneration made necessary by the decline in purchasing power which has already taken place.

Examination of Witnesses

L. E. BALDING, *Chairman of the Council*

R. G. SWISS, *Chairman, General Dental Services Committee*

C. W. F. THOMAS, *Chairman, Royal Commission Sub-Committee*

J. P. COCKER, *Vice-Chairman of the Council*

T. HINDLE, *Vice-Chairman, Remuneration Committee*

PROFESSOR R. G. D. ALLEN

H. PARKER BUCHANAN, *Secretary*

H. D. BARRY, *Deputy Secretary*

G. W. MARSHALL, *Assistant Secretary*

R. C. SIMMONDS, *Actuary*

H. J. FRICKER, *Statistical Adviser*

on behalf of the British Dental Association
Called and Examined

3030. *Chairman*: Mr. Balding, you will know that representatives of bodies appearing before us will be tested fairly thoroughly on what they wish to say and what they have put in their memoran-

dum. I hope you will understand that this does not imply either disbelief or hostility on our part, but we have got to question you, otherwise there is nobody else to do so. We have a long

and very interesting memorandum from you. We certainly cannot cover all the points in detail and I do not think you would expect us to do so. It does not necessarily mean that they are irrelevant or that we accept them. We have had evidence in respect of some of these points, on somewhat similar lines from, for instance, doctors, so not everything need be gone into in great detail. Any member of the Commission will be asking questions, but we have in fact allocated the task of going through your evidence to a sub-committee, of which Sir Hugh Watson has acted as chairman, so he will be leading the questioning. I take it you will be the principal spokesman, but you may wish some of your colleagues to intervene?—*Mr. Balding*: Yes, Sir.

3031. Would you perhaps start by giving us, really for the record, because much of it is in your evidence, just a quick outline of the structure and status of your Association and its representative character; and perhaps you might care to add a word about its relationship with other bodies?—*Yes, Sir*. The British Dental Association has been in existence for a very large number of years. In its present form it dates from 1949-50 when it amalgamated with the two other dental organisations then existing to form one united British Dental Association.

The membership of the Association, according to this morning's figures, Sir, is 10,889. We say 11,000 in our memorandum; it is just below that at the moment. Any dentist on the Dentists' Register is eligible to apply for membership. He has to be elected by the Council of the Association and the Association comprises dentists in all walks of professional life. The vast majority of our members are in general dental practice; quite a considerable group are in the public dental service; and quite a large group of members are in the armed forces. We have, of course, consultants and specialists, hospital officers, and university teachers and professors. All are represented in the Association.

In addition, Sir, we have a special standing committee known as the General Dental Services Committee, which is partly elected by the Association and partly elected by the independent bodies that were set up under

the Health Act, that is, the local dental committees, who have direct representation to the extent of half that Committee. It is a Committee of some 70 people and the local dental committees elect their representatives to it. The men they elect need not necessarily be members of the British Dental Association; they have an entirely free choice in their election. The General Dental Services Committee, as a standing committee of the Association, is the body that does all the negotiating with the Ministry of Health on all matters connected with the Health Service.

With regard to our relationship with other bodies, Sir—if you mean dental bodies—we have no connection whatsoever with any other dental body, either officially or unofficially.

3032. Among your representatives here today, do some represent as it were different sides of dentistry, or are you all really general dental practitioners?—*We are all general dental practitioners*. Mr. Swiss is the Chairman of the General Dental Services Committee, Mr. Thomas the Vice-Chairman. We have with us, Mr. Cocker who is our representative on the Joint Committee of Specialists; but we understand that he will be present the next time the Committee attend to give oral evidence. I think the last time the Joint Committee attended they asked if they could bring a dental representative, so we are not proposing today to speak on consultant and specialist matters, Sir.

3033. The British Medical Association gave us a very long book of preliminary evidence and are following it up on particular matters dealing with particular branches of the medical profession. In your case, apart from anything that may arise out of what we deal with today, you are not proposing to submit any further memoranda?—*No, Sir*, I do not think so, unless anything arises on matters connected with the Royal Commission's questionnaire or something like that, or the result of the Inland Revenue enquiry which we have just received this week—and at which we have only had a very quick preliminary glance. We have also just looked at the statistics on mortality published last Thursday. But it is not our intention at the moment as far as we know to give you any further memoranda unless anything arises out of these.

3034. *Professor Jewkes*: The Inland Revenue enquiry is the one into expenses?—Yes, the figures came in on Monday, Sir, and we have since had a note from the Inland Revenue to say that the figures are not quite accurate and they wanted to correct them, so we have not the final picture.

3035. *Chairman*: But the figures give a broad picture considered to be an indication?—Yes, but I would not like to commit myself as we have not considered them in any way at all.

3036. Have you considered the mortality figures?—Only very quickly.

3037. Do you find yourselves more depressed than before? You made quite a reference to them in your memorandum.—I think we still have the doubtful honour, Sir, of topping the table in the professions.

3038. *Sir Hugh Watson*: Mr. Balding, before we come to the main subject of this inquiry which, as you know, is into remuneration, there are a number of other points with which you deal in your memorandum on which we could perhaps usefully touch first.

To begin with in your paragraphs 13, 14 and 15 you talk, quite understandably, about the importance of dentistry from the point of view of general health. I notice that the McNair Committee in paragraph 32 of their report, having enquired into this matter, came to the conclusion that the number of diseases which can fairly be attributed on reliable evidence to bad teeth is comparatively small. They added, however, that this was not to say that dentistry was of no importance in securing a general sense of health and wellbeing and that it was obvious that bodily health would be incomplete if dental health were lacking. Then went on to list four particular ways in which dentistry contributes to the health and efficiency of the community. Would you agree that this is a fair statement of the functioning of the dental profession?—I think so, Sir, yes.

3039. There is one matter about which I am a little puzzled and that is the way in which in your profession you regard partners and partnerships; in other words, I am not quite sure whether the dental conception of the status of a partner is somewhat different to that in other professions. I am a lawyer and in

my profession my partners are all regarded as principals. Do I understand in the dental profession the senior partner is the principal and the rest, his supporting colleagues?—No, I do not think so, Sir. Partners, apart from the actual division of the partnership profits, are all on the same level, I think.

3040. In these tables where reference is made to principals, that includes all the partners of a firm?—I think so, yes.

3041. Mr. Balding, in paragraphs 18, 19 and 20 you deal with the question of the training grants which are available. In paragraph 16 you outline in a general way the cost of training of a dentist and I notice that you put the period in the dental school at four and a half to six years. We have had suggestions from other medical bodies that the course of instruction to which surgeons are subjected today is possibly unnecessarily long. Would you think there was any room for curtailment of the course of instruction for dentists?—No, Sir, quite definitely not.

3042. What puzzles the Commission a little, I think, is that it should be necessary for a dentist—who admittedly has to do complicated operations on one rather inaccessible portion of the human anatomy, not forgetting the bit about the conscious and apprehensive patient—has to undergo a full course almost equal to that undertaken by a surgeon who has to operate on all parts of the body.—Yes, Sir. I think it is fair to say that in this country the university authorities and those responsible for the dental curriculum try not to forget that the mouth is part of the body. We do not in this country go in for training people in the purely mechanical work of filling a tooth without realising that they will be dealing with part of the human body, and must have some background of medicine if they are going to be proper dentists, and not just tooth carpenters, shall I say.

3043. I quite understand. I just want to be clear. You carry that so far as to say they must participate in the full course of instruction?—Yes, Sir. The courses of instruction that are undergone in some of the subjects by dental students are not quite as long as for medical students, particularly such subjects as dissection and anatomy. Dental students have to do a considerable

course in dissection but I do not think it is quite the same length as for a surgeon because dental students have a lot of specialist subjects to get on to later on in the curriculum that doctors do not learn about at all.

3044. Do some of your students take the full course but not take the degree in these subjects?—I do not quite understand.

3045. The full qualification now in the case of Edinburgh, for instance, is L.D.S., R.C.S.Edin., is that right?—Yes.

3046. Is it still practicable for a dentist simply to take the L.D.S. qualification?—That depends on where he is being trained. The one you have mentioned of course is granted by the Royal College of Surgeons of Edinburgh who, of course, do not grant degrees but only licences in the same way that the Royal College of Surgeons of England still only grant licences. There is a higher diploma, the F.D.S., but it is not a university degree.

3047. It is a diploma?—Yes, whereas some universities still have students taking the L.D.S. of the university or possibly of one of the Royal Colleges, there are some universities, I think, that have virtually dropped their licence in dental surgery and insist on all students taking the B.D.S.

3048. In your paragraphs 18 and 19 you touch on the question of what financial assistance is available to students to help them through their dental career. In paragraph 19 of your memorandum, where you are quoting from the Association's evidence to the McNair Committee, you say:

"While this arrangement is doubtless intended to operate in a perfectly fair manner, it appears to the Association that there is a distinct risk of some potential dental students being handicapped in so far as local authority awards, as distinct from State scholarships awarded by the Ministry of Education, are concerned."

Any disadvantage there is is general on this point to all professions, is it not? I am leaving aside at the moment the special point you make at the end of this paragraph.—Not necessarily so. The local authorities, being autonomous bodies, can decide in the first place how much money they are going to give in

grants, but there is also this difficulty we have found, that some local authorities do not appreciate the importance, shall I say, of dentistry. They find the course takes perhaps six years and they can get two students through three-year courses by expending the same sum of money as for one student doing six years of dentistry and there is a certain amount of—I will not call it prejudice so much as lack of appreciation of the training of dentists, the time training takes and the value to the community.

3049. In your memorandum, at the end of paragraph 25, you describe it as "prejudice, perhaps unintentional"?—Yes.

3050. Apart from that factor, the same considerations could be in the mind of a local authority with regard to grants for a degree in medicine, could they not?—Yes.

3051. Or for a lawyer or for any other profession which requires a long training?—Yes.

3052. The point I am trying to make is that if the dental profession feel themselves handicapped by the way in which local authorities award grants, apart from the possibly unintentional prejudice with regard to dentistry, the same applies to all other professions?—Yes, apart from what we call the unintentional prejudice, which I think, undoubtedly exists, that if a student says he wishes to be a doctor that is regarded in some areas rather more favourably than if he says he is going to be a dentist and he is perhaps more likely to get a grant.

3053. *Professor Jewkes*: Is that not one reason why you ought to think about the possibilities of cutting the period of training for dentists?—With respect, I feel that is the wrong way to tackle it. The way to tackle it is to educate local authorities into the needs of dentistry and what dentistry means and is, rather than to cut it down so as to hope to attract grants from the local authorities.

3054. We have of course discussed this point recently with a number of the medical organisations and they suggested that because of the increased demand for scientists, and because the scientist can get his degree in three years, there is a great danger that medicine would not get a due quota of recruits unless it was

prepared to think of a shorter period; and there were also other advantages in cutting down the period. But is it not always going to make it difficult for your profession to get your full quota of recruits if in fact there is this steadily increasing competition?—That may be so, but we have never felt that the right answer to it is to cut down the dentist's training. Dentistry is, if anything, like medicine, getting more complicated, and there is more to learn if one is to be an efficient and up-to-date practitioner, and we have certainly never contemplated cutting down training. Not that, you will appreciate, we have anything to do with the fixing of the dental curriculum—that is done by the General Dental Council.

3055. *Mr. Bonham-Carter*: I am right in thinking that during the last two and a half years of his training, the young dentist is in fact practising in hospital under supervision?—Yes.

3056. *Chairman*: Have you actually considered this question recently, as an Association. *Mr. Balding*?—We did consider it, Sir, both when we were giving evidence to the Guillehaud Committee and the McNair Committee. We had considered even the suggestion that we should make an approach to those universities who no longer grant an L.D.S. and insist on their students taking the B.D.S., because the L.D.S. is a slightly shorter course, a few months shorter. But we felt it was wrong, Sir, and that the more university graduates there were in dentistry the greater the status of the profession would become and that it would be quite a wrong way to tackle a shortage of dentists, to rush through a lot of half-trained or semi-trained people, or people without the fundamental knowledge that it has always been considered a dentist should have.

3057. The surgeons did not put it to us in Scotland last week when we were talking to them, that it would result in any less thorough training or acquisition of fundamental knowledge. They thought the course was too long for the amount of knowledge to be acquired. You would not feel at present that would apply to dentistry?—No.

3058. In other countries who are up-to-date in dentistry the course is about as long as here, is it not?—*Mr.*

Buchanan: Sir, in a great many dental schools in the United States of America admission is limited only to those who have already taken an Arts Degree, B.A. That stretches their course to about seven years. In Scandinavian countries about seven years is usual and sometimes even longer.

3059. Do you know how that compares with doctors in those countries?—Very much the same, Sir.

3060. *Mr. Gunlake*: Does the Ministry of Health concern itself in any way in the length of the curriculum?—*Mr. Balding*: I would not say they were not interested. They have representatives on the General Dental Council, nominated by the Crown; but the Ministry of Health, as such, does not control the length of the curriculum. It was controlled of course by the General Medical Council up to two years ago, but the General Dental Council has now entirely taken over the functions of the General Medical Council as regards dentistry.

3061. *Sir Hugh Watson*: Coming back to the question of grants, *Mr. Balding*, in your paragraph 18 you point out that there is in effect a type of means test in force with regard to the income of parents. That again applies to grants for people studying for all professions, does it not, not only dentistry?—Yes, it does of course. We make the point there that if dentists are paid on the basis of the Spens recommendations then the grants they are likely to get from a local authority for their children's university education are very little, if anything at all, and leave the major cost of training to be borne largely by the parents.

3062. If dentists are paid according to the Spens recommendations, the amount of available grant is very small. That would mean that the Spens payment could be fairly high, would it not?—Not necessarily, Sir.

3063. I am a little puzzled about this question of grants because there is a scale laid down with which you and I are quite familiar. After certain permissible deductions one arrives at a standard income and on that income figure the parents' contribution is based. But certainly in Scotland one has been familiar for a very long time with the willingness of parents to pay for their children's university education and it

does not appear to be an enormous hardship. Certainly it does not appear to be a hardship amounting to a positive deterrent for parents to pay these sums. After all, if the student was at home he would have to be maintained at home?—Yes, Sir.

Sir Hugh Watson: I think the dental profession is in the same position as most professions in this regard.

3064. *Chairman:* In fact, Mr. Balding, on the basis of the Spens recommendations, at the time the average dentist would be paying for his children's university education his income would be rather less than a few years before, and so they would be rather more eligible than people in some other professions. Have I got that right?—That depends on which recommendation of Spens you are taking.

3065. *Sir Hugh Watson:* In paragraph 23, Mr. Balding, you point to the fact that dentistry is not a career for which study can be undertaken on a spare time or part-time basis as is possible, for example, in the case of the legal profession—and you put in brackets the word "solicitors". I am a solicitor and the position in that profession is that during his apprenticeship the solicitor works whole-time in the law office. Neither in Scotland nor England does he earn anything of any significance; furthermore he is not entitled to any grant from a government department or local authority because he is not whole-time at university. My whole point, Mr. Balding, is this: I do not think dentistry in this matter is any worse off than any other professions.—We understood, Sir, in certain cases local authority grants were made.

3066. In Scotland they certainly are not, and I enquired of the Secretary of the Law Society in London. I did not put to him the local authority point, I am bound to say. I asked him whether any grants were available and he said no.—It was I think, Sir, more a question of people in local authority work. I think they receive some remuneration while they are in local authority offices.

3067. That may be, but their number is inconsiderable and I would say in general, articulated clerks in England and apprentices in Scotland, and the large body of law students, are paid nothing at all. And there are other professions; for example, engineering apprentices get

very little. Would you agree this is a matter in which the dental profession is not at a disadvantage compared with other professions?—No, Sir. If there are professions in which apprentices or articulated clerks or others can obtain posts, I would only say there are no such posts in dentistry. I do not want to press it at all, but that is just the position.

3068. I accept that. I notice that the McNair Committee came to the conclusion that arrangements for financial assistance from public funds for students in dental schools have not been adequate. Would you agree that that applied to all educational grants? This is page 59 of the McNair Report, in the appendix.—I suppose it applies to a certain extent to all professions. The McNair Committee was primarily concerned with dentistry and I think it is quite a fair remark to apply to dentistry.

3069. On a kindred topic in your paragraph 19, Mr. Balding, you suggest dentistry is an unpopular profession. Why exactly, in your view, is the profession unpopular among prospective entrants to it?—I think, Sir, it is partly—and I think the McNair Committee thought this too—because of the public ignorance of the nature of dentistry and public apathy towards dental health and the importance of dental health. Consequently, while there is perhaps a certain amount of publicity and glamour in the young person's mind that he may one day become a doctor or a leading surgeon or become a barrister and later a leading Q.C., that does not exist in dentistry.

3070. You develop this point in your paragraph 31, actually in the last sentence, and you point out that in Scandinavian countries the people hold dental surgery in the highest esteem.—So we understand, yes.

3071. *Chairman:* How do you assess a statement like that? I do not know how you establish that dentists are held in the highest esteem in a country.—I admit it is difficult to assess, definitely, Sir, but we have, of course, an International Dental Federation that gets together and discusses all sorts of problems, and we also I think still have quite a number of Scandinavian students in the dental schools in Great Britain, particularly in Scotland.

3072. And it is more fashionable, as you might say, there than here?—So

we understand, yes. It is a thing one cannot produce definite evidence on. It is just what we hear from these students and from our relationship with these international bodies.

3073. Is it a long term business to build up the prestige of any one profession in the public mind? It probably is. Are there any particular ways taken in Scandinavia to do that?—*Mr. Buchanan*: I think, Sir, perhaps it is helped by the length of curriculum compared with some other faculties at the universities. These things, as *Mr. Balding* said, we do learn a bit about through our International Dental Federation. It was a great surprise to us some six years ago, for example, to discover that a Latvian qualification in dentistry—I think something in the region of 80 per cent. of the dentists in Latvia are women—gives automatic admission to our Register in this country. Until then we had scarcely realised there were dentists in Latvia, so in that vague kind of way we have a fair knowledge nowadays. At the Congress in Rome last September something in the region of 80 nations were present. This Federation has been in existence for almost sixty years and helps us to assess relative international social and economic status.

3074. Looking at it over a long term, do you consider that on the whole dentistry as a profession is improving in prestige in this country?—Yes, indeed, Sir, wonderfully. In the last 20 or 25 years it has improved out of all recognition in all ways. In the universities we now have over 20 full university professors who have precisely the same status as the regius professor of medicine.

3075. I was looking at it particularly in the way the public look at it.—Within recent years we have achieved in the armed forces the rank of Rear-Admiral, Major-General, and Air Vice-Marshal. That is the sort of thing that does help, of course.

3076. *Professor Jewkes*: I suppose one indication of this is that in other countries they have many more dentists per hundred of the population than we have. You accept the figures, I think, in the McNair Report?—*Mr. Balding*: Yes.

3077. Has anything been done to implement the recommendations of the McNair Report that more women should be encouraged to enter the profession?—Not as far as I know, specifically. We are not opposed to that and are all in favour of getting as many women dentists as we can.

3078. *Mr. Bonham-Carter*: What is the present proportion of your membership who are women?—*Mr. Buchanan*: There are 1,250 women on the Dentists' register.

3079. Out of 16,000?—*Mr. Balding*: Yes.

3080. *Chairman*: Years ago it would have been a very much smaller percentage?—Yes, Sir.

3081. The figure 1,250 is a larger proportion of dentists who have qualified since the war, more than 1,250 out of 16,000?—*Mr. Buchanan*: I do apologise, Sir, that the figures are not available. We will try to work out a graph.

3082. *Mr. Bonham-Carter*: The majority of them are in fact practising?—Yes, I think so.—*Mr. Balding*: It is a profession that lends itself particularly to women; even married women with families can still practise. They take the sessions in the school dental service where they can take any number of sessions up to 11, and if it suits them to do three sessions they do three. Perhaps, if they have another child it means they cannot give so much time, so they can cut it down to two. But it is a profession that does eminently suit women with other commitments; they can practise part-time, and I think a very large number of married women do in fact do so.

3083. *Professor Jewkes*: My deduction from what *Mr. Buchanan* said was that perhaps 10 per cent. of the dentists in this country are women.—Something like that, a little bit under perhaps.

3084. We have not the figure for Latvia but we have Finland—75 per cent. female, Sweden—40 per cent.; why this disparity?—*Mr. Thomas*: I think possibly the answer, Sir, is tied up with the school dental service. Private practice is very onerous and there is no doubt that the metier of a woman would be in the school dental service and our school dental service is not all that it should be—I mean as far as numbers are concerned—and that really does mean that

there is such a lower proportion of women in the profession.

Chairman: These figures we are quoting here relate to women students: 12 per cent. in England and 30 per cent. in Norway, 75 per cent. in Finland—the students in recent years.

3085. *Mr. Bonham-Carter:* Mr. Balding, do you happen to know if it is customary in any other country for the practitioner to use a chair? Is there any relationship between that and the number of women?—*Mr. Balding:* I have never heard that suggested at all.

3086. I have heard many dentists talk of working from a chair but have never seen one doing it.—I have certainly never heard that suggested as a reason why there are less women dentists in this country.—*Mr. Buchanan:* It is a custom which is growing in this country very considerably. It is what all dentists in the Naval dental service learn to do: they have to. With three point contact you can work when the ship is moving gently in calm water.

3087. *Sir Hugh Watson:* Mr. Balding, could we turn now perhaps to the state of recruitment—your paragraph 49. In the first place what does your Association consider the number of dentists in practice should be.—*Mr. Balding:* I think, Sir, that we have no reason to disagree with the old Teviot Committee recommendation that there should be 20,000. It is extremely difficult to assess exactly what the real need is but we would certainly accept that figure of 20,000.

3088. *Chairman:* It is about one to every 2,500 of the population, assuming they are all full-time, which is rather more actually than in some countries, but rather less, for instance, than in Canada. But you feel that is about right?—Yes.

3089. *Mr. Gunlake:* Would that meet the public demand that exists or the public demand that in your professional view ought to exist?—That is where it becomes difficult to assess that figure. Public demand has increased, there is no question about that although it is a slow business. The public is gradually becoming educated into the necessity and the wisdom of looking after their mouths, so I was a little guarded in saying we would accept the figure of 20,000. But when the time of full demand arrives, and it will be very many years ahead,

it might be an inadequate figure, or possibly if we have found by that time some prevention of disease it might be a surplus figure—we do not know.

3090. *Chairman:* That figure also depends, I suppose, on the extent that you are likely to be able to use people who are not qualified dentists. It must vary quite a lot according to how much the dentist is doing himself that is not absolutely essential to his qualifications?—Yes.

Chairman: Is there scope for much there? Perhaps we could come on to that later.

3091. *Sir Hugh Watson:* You mentioned the need, Mr. Balding. There is also the question of demand, which is a different thing?—Yes.

3092. And the latter could be affected very much by situations quite outside the control of your profession, as you have seen already?—Quite.

3093. Would you agree that 800 was the desirable number of recruits into the profession each year until you had built up to the Teviot 20,000?—800 finishing?

3094. No, 800 first year students coming in. I beg your pardon—900 coming in and 800 finishing. You are quite right.—We would go for the McNair figure which was 1,000.

3095. These would include some people only here for the purpose of being trained, foreigners in other words?—Yes, quite.

3096. But of 900 students, allowing for wastage, they would emerge from dental school as 800?—Something like that. We could certainly do with that. We are not only not disputing that figure, but continually trying to press on to get that number of places.

3097. You know, of course, following on the McNair report, there has been an appreciable increase in the number of students entering the schools?—Yes, Sir.

3098. Post, if not proper, anyway. Just for the record, in 1953-54 it was 451; in 1957-58 it was 632?—Yes, I am sorry. I was thinking for the moment that you said the number of places had increased.

3099. *Professor Jewkes:* Why has there been this remarkable increase in

entrants, do you think?—It is a little difficult to assess that exactly. I think it is due to a number of causes. One was I think the mere setting up of the McNair Committee and certainly the report of the McNair Committee. There has also been a certain amount of stimulation from bodies within the profession such as the General Dental Council or the old Dental Board and ourselves in co-operation with them, going round and talking to senior pupils in schools. There are a whole variety of things that have been put in train but I would say my own opinion is that the McNair Committee and the publicity given to it and to the report probably did a great deal.

3100. *Mr. Bonham-Carter*: For the record, I think we may have gone wrong here. Am I not right in saying that you go for the McNair figure, 1,000, not the 900?—1,000 students, yes.

Chairman: Yes, but that 1,000 includes some from overseas, I think that is clear.

3101. *Sir Hugh Watson*: *Mr. Balding*, in your paragraph 62 and also in paragraphs 95 and 97 you refer to the Spens conception of 33 chairside hours a week for 46 weeks in the year, plus nine non-chairside hours. Do you consider that should be the norm for a fully employed dentist?—*Mr. Thomas*: Yes, without any doubt, Sir Hugh.

3102. From such information as is given in the Spens Report we are not told exactly how the Spens Committee arrived at that figure. They just say they had—I have forgotten the expression—ample evidence.—*Mr. Cocker*: I think, if I may speak as a member of the Spens Committee, that practically all the witnesses who came before us, did make some statement on this. It was really built on evidence.

3103. Would you consider that the longer hours referred to in paragraphs 95 and 97 would be undesirable?—*Mr. Thomas*: Yes.

3104. At all ages, *Mr. Thomas*?—The effect of working longer hours at a younger age impairs the length of the practitioner's useful working life.

3105. That would be a question of degree, would it not?—Quite.

3106. I think I could say with you that when you and I were young we

both had to work very hard.—That is true.

3107. Would you agree, within reasonable limits, that a man up to the age of perhaps 45 to 50 could, without material disadvantage, work appreciably longer than 33 chairside hours?—There is not the slightest doubt that at the present moment a lot of them are doing it, but I do not say that it is a good thing from any point of view.

3108. *Chairman*: Do you say it is bad thing?—Yes.

3109. Do they say it is a bad thing?—They have not had the experience that I have had, Sir. They do not know yet.

3110. *Professor Jewkes*: *Mr. Thomas*, let us have your experience. Is it that you worked too hard when you were younger and that this has impaired your efficiency later on? Is that what you are saying?—I think it is perfectly true as far as health is concerned. As far as my efficiency as a practising dentist is concerned, I am very tired now before the normal five or six hours, or rather before the time which should be a normal day; in other words, by half past four I am tired.

3111. *Chairman*: Was that not envisaged in the recommendations? Was it not stated that a dentist would not be expected to do as much later on in life as earlier?—I think provision was made for the exception, but the report was for normal people.—*Mr. Hindle*: A great bearing on this question, Sir, is that a dentist has a great mental strain dealing with patients, and if he gets overtired his approach to that patient suffers. It is a very important point, particularly in dentistry and more than in most other professions, that the dentist must not be tired when he is doing his work, or he fails in his approach to the mental condition of the patient. The general happiness and contentment of the patient is essential if he is to do a good job.

3112. You would agree, *Mr. Hindle*, that individual capacities vary very much from one to another?—Undoubtedly, and Spens made a point of that, that you could not lay down hard and fast rules because there are exceptional people; but in my long experience I would say I have not come across any of those men with the capacity to work long hours who

have stuck it through a long professional life; they have had illness or died. I have seen lots of dentists, who have dropped down in that fashion by working too long hours. In dentistry there is something different from most other professions. If you are at the chairside you are surely working the whole of the time and the whole of the day; you do not get half an hour between each patient because you are going from one to another and it is very arduous.

3113. *Mr. Gunlake*: You have spoken, if I may say so, rather convincingly on this point. One remedy would be more dentists? Have we heard if the British Dental Association is taking positive action to increase the number of dentists?—*Mr. Balding*: I mentioned that we were co-operating with the General Dental Council in sending speakers round to the sixth forms of schools, senior students, that sort of thing. We are also continually on at the universities and the Government about providing more places in the dental schools. As a result of the McNair Committee Report, and, I think, a certain amount of prodding from the British Dental Association, the Ministry of Health have recently set up a committee on publicity as regards dental health, which we have been asking for for over 70 years. At last we have got it and we are convinced, as was stated in the McNair Report, that it is fundamental to the whole problem, that if you can only convince the population of the importance of dental health, you can get your recruits and everything else you want.

3114. I was not thinking so much of action by the other agencies as by the British Dental Association itself and you are doing all you can in this field?—*Mr. Buchanan*: Sir, we are proud of the fact that only after considerable difficulty did we bully the authorities into setting up the McNair Committee—it was largely a child of the British Dental Association—with the sole purpose of deciding what was wrong with us, why our sons, daughters, nephews and nieces were not entering the profession.

3115. *Professor Jewkes*: This question of chairside hours is so important that you will forgive me if I press you a little hard on the figures. In the Spens Report it is laid down that 1,500 chairside hours a year represent full, but not

excessive, employment. Then the Spens Committee go on to say that employment in excess of those hours tends to impair efficiency. The next study we have is the Penman Report. In the Penman Report of 1949 it is laid down that there is clear evidence that the majority are working more than the Spens standard. Then in your own claim to the Ministers you say that according to the 1952-53 inquiry, single handed dentists work more than 2,100 hours a year. You go on from there to say that the present figure is even higher than 2,100. So am I drawing the right deduction when I think that for 10 years now the dentists have been working considerably longer hours than Spens regarded as the maximum if efficiency was to be maintained?—I do not think there is any question about that, Sir. The dental profession had in 1948 to meet a quite unprecedented demand for its services, one that it had foreseen but could do nothing about. It was thrown on them. There was no doubt at all that in 1948-49 it was not a question of dentists working 33 hours a week; they were working anything up to 16 or 18 hours a day by the time they had finished all their non-chairside work as well, because the more chairside work you do the more non-chairside work you have to do afterwards. They were working Saturdays and Sundays because they were just flooded with this colossal demand which quite obviously should have been anticipated but which was just thrown on the profession. Since then the demand, that initial rush, has of course been got over but there is a constant and increasing demand, and the dental profession is in an extremely difficult position. If it works more than the Spens hours then we get this suggestion that in fact the Spens hours do not mean anything. If the whole profession were to stick rigidly to Spens hours the outcry from the public that they could not get dental treatment would be enormous. There would be a terrific scandal about it. The profession has to meet the demands for its services as far as it can, but that does not mean to say the Spens recommendation for 33 hours is not the right one.

The school dental service—where I will admit the conditions are different, the patients they work on and so on are possibly more trying than some of the patients we meet—are dealing the whole

time with small children and the nervous tension when working on young patients is very much greater. In the school service, the normal hours for a session are three, and there are two sessions a day which brings the chairside hours to 33 a week. There has never been any suggestion of increasing those hours without loss of efficiency in the service.

3116. So that it really means that progressively for 10 years the efficiency of the profession has been falling, has it? —Not necessarily, because during that ten years there have been a certain number of elderly men retiring who were in the service in 1948 and who have been replaced by younger men coming in, and Spens does anticipate that there will be a proportion of, particularly younger, men who can do more than the 33 hours.

3117. *Mr. Bonham-Carter*: Who are nevertheless running on their reserves? —Yes, in the long run, undoubtedly.

3118. *Professor Jewkes*: What exactly does it mean when it is said the efficiency of the profession is falling? What form does it take, this impairment of efficiency?—I would not say, Sir, that the efficiency of the profession in its day-to-day operation is falling, that is not so. It takes a very considerable drain on the length of a man's professional life. As you know from the latest figures we have had from the Registrar General, the dental profession is still at the top of the professions as regards the number of people who die just at the time when an ordinary professional man should be at his best, that is, at 45 to 55. We have not had a chance of really analysing the figures, but I think I am right in saying that the number of deaths from coronary thrombosis shown in those tables for the dental profession are very much greater than apparently the Registrar General anticipated, according to his records. They have gone up tremendously and of course, unfortunately, the dental profession still tops the professions as regards suicide.

3119. *Chairman*: Is that a reflection on the quality of the students?—No, Sir, I think it is a reflection on the fact that the dental profession is literally overworked and that the nervous strain of dentistry is so tremendous. Obviously a young man of 22 or 23 coming into practice is not inclined—is anyone of

that age—to consider what his health is going to be when he is 45?

3120. *Mr. Watson*: Mr. Balding, does that mean we must accept that all this new equipment and all these new techniques have impaired the efficiency of your service?—No, Sir.

3121. Would it not be correct to say new techniques and equipment have improved the efficiency of the dental service?—Yes, Sir.

3122. *Chairman*: Dentistry is a particular part of the whole problem we are dealing with, and dentistry relies on expensive equipment of a better type than was available say 50 years ago, which ought to be, as in any other occupation in life, an aid to efficiency? —Yes, Sir, but it still does not get over some of the fundamental disabilities of dentistry, in other words the occupational strain of dentistry. It merely enables a man to work better.

3123. To work more effectively?—Yes.

3124. You might still only be able to do the same number of hours but you can drill more holes in the same time, as an example?—Yes. The introduction many years ago of local anaesthesia, for instance, changed things tremendously, but that does not mean to say a man can work longer hours necessarily. He can do more in the hours that he does work.

3125. If the profession is improving in efficiency in the normal way, it would be able to do more work in the same number of hours, or do it better?—Yes.—*Mr. Thomas*: With regard to what the Spens Committee meant about impaired efficiency, I do not think it was the efficiency of the operation on the patient that he was referring to, but the efficiency of the practitioner himself in as much as he may be tired physically and psychologically and unable to work for such long periods. It was not the efficiency of the treatment of the patient, but the efficiency of the machine, the man himself.

Chairman: I think we realise that.

3126. *Professor Jewkes*: Would not that finally have its reactions in an impairment of the efficiency with which the patient himself is treated?—*Mr. Balding*: If it went on long enough, yes, of course; obviously the stage would be reached where the dentist was so

tired that he just could not do the work properly.

3127. I thought that was what impairment of efficiency meant—from the patient's point of view.—*Mr. Hindle*. Could I say that efficiency means the method of conducting his practice? I would like just to give you an example of a man I know who has worked harder in dentistry than any other person I have ever met. His efficiency was beyond any criticism. That man has just been ill for two years and has not been able to do any work at all and he is only now 55, so his efficiency has been impaired. Had he not been ill for two years, had he worked more economically, he would not have had that inefficiency.

3128. *Chairman*: Mr. Balding, coming back to the question of the 33 chairside hours, are many dentists now getting more into the 33 hours by passing on some of the work? One has heard some of the cases where a bit of preparation is done beforehand and the dentist comes along and the patient is all ready for treatment by the time the dentist comes to him. It may be that the dentist is, for instance, working on the manufacture or preparation of dentures which is not a chairside job, I presume.—*Mr. Balding*: I think that surely is inherent in the Spens Report—a single-handed dentist working efficiently and making full use of all facilities. There is no doubt at all, Sir, that dentists are doing that. They have chairside assistants to relieve them of non-operative procedures, just in the same way that a surgeon doing an operation does not expect to turn around and pick up his needle and have to thread suture through for himself. The sister does it for him and hands him the thing all ready threaded. That is what Spens meant by chairside assistants.

3129. I wondered whether that was increasing in any way or not, over the years?—Yes, I think so, Sir.

3130. And on the whole the dentists are doing rather more chairside hours by relieving themselves of some of the less essential jobs for their own particular qualifications?—There is no question about that, Sir. I mean, such simple things as mixing fillings and preparing local anaesthesia for the next patient, before the next patient even comes into the room—all that is done

by efficient surgery nurses and chairside assistants and that is certainly going on the whole time. I should imagine it is increasing, if it is possible for it to increase. I think most dentists do now organise their practices so that they do not do that sort of thing themselves; it is a waste of time as far as they are concerned, their job is to operate on the patient.—*Mr. Swiss*: That, Sir, is particularly so with reference to paper work in the practice. The practitioner is employing more secretarial staff. We have heard of it on the one side of the application of the treatment to his patient by having surgery assistants, just as the surgeon has his theatre sister; so on the other side of his practice he is employing additional lay staff for secretarial work and all the work involving papers in connection with the Health Service. So that he is not tiring himself at the end of a busy day of operating, by having to do the bookkeeping of the practice.

3131. Yes, I was really wondering whether the 33 had rather gone up, because the nine—the difference between 42 and 33—had rather come down with the use of more assistants?—Yes, Sir.

3132. *Mr. Gunlake*: However, although these arrangements may save the dentist a certain amount of work, I should have thought to some extent they would increase the strain. A few seconds breather while you mix a filling might be a welcome break; but the dentist is, as I understand it, continually at top pressure?—The pressure is the demand on his services. He has such a demand on his services that he has not time for breathing spells. But if he was working to the 33 hours that type of breathing spell would probably be available.

3133. *Chairman*: In fact between every visitor there is a space, is there not, for smiling the next one in?—And that is very necessary, Sir.

3134. What the statisticians would call unidentified time?—And I think dentists are continually enlarging their premises, so that when a man has finished his work on one patient he walks into No. 2 surgery—he walks straight from one patient to another—and by that means he is able to save quite a lot of time. You will see what I am getting at; that is added strain.

3135. *Professor Jewkes*: I wonder if you can help me to get the critical figures. Spens lays down 1,500 chairside hours per annum, Penman suggested 1,750 were being worked, and you yourself give the figure of 2,100 chairside hours for 1952. Have you any figure for 1957 and 1958?—*Mr. Balding*: I have a slight correction, Sir, for the last figure; that 2,100 was not all chairside.

3136. We are both talking about the figure that was put into the dental profession's claim to the Ministers?—Yes.

3137. But it is not all chairside?—I do not think it is.—*Mr. Thomas*: The inquiry could not differentiate.

3138. *Chairman*: In fact, 2,100 is 42 hours a week?—Yes.

3139. On the same basis that 1,500 is 33?—Yes.

3140. So you are really saying, if 2,100 includes all the non-chairside hours, that the total amount is as envisaged by Spens but you have not got the split between chairside and non-chairside? Is that it?—That is quite correct, but of course, the new inquiry will, we hope, give more up-to-date figures.

3141. *Sir Hugh Watson*: We hope it will give it more precisely than anything that has yet been available.—Yes.

Mr. Gunlake: It is to be hoped that busy dentists will not be too busy to fill up our questionnaire.

3142. *Professor Jewkes*: But, at any rate, at the moment you have not got an up-to-date figure which would correspond to the 1,500 from Spens?—*Mr. Balding*: No. We have no means of obtaining figures like that, only when these inquiries take place. The figure of 2,100 was based on the 1952/53 inquiry, and that was why we were insistent in asking that the Royal Commission should put in their questionnaire to dentists a question on the hours of work, because we have no up-to-date information and nothing to give you at all.

3143. *Sir Hugh Watson*: We are really looking towards the future, but there is one point I would like to try and establish. Am I right in thinking that, at the inception of the National Health Service, a very large proportion of the work which the dentists were called upon to do was in connection with the manufacture of dentures? Would it be of the order of two-thirds

to one-third?—*Mr. Thomas*: What year was that.

3144. 1948-49.—No, I should think it would be about 50 per cent.

3145. *Chairman*: About 50 per cent. was the manufacture of dentures, and about 50 per cent. was other work?—Yes.

3146. *Sir Hugh Watson*: I have been given the figures practically officially as being two-thirds and one-third. Would you have information which would enable you to dissent from that? I am told further that since the introduction of the charges for dentures, the proportion has been exactly reversed and is now one-third dentures and two-thirds ordinary treatment.—*Mr. Balding*: I think, so far as our information goes, that is so.

3147. I have a small point arising out of Mr. Watson's question on the improvement of dental methods, and so on. I suppose you know much better than I do that a great deal of the dentists' remuneration depends on the timing of the operations. Am I right in thinking that these timings were last reviewed by the Penman Working Party in 1949?—Yes.

3148. And it could be that these timings, which are now nearly 10 years behind, are due for review?—Yes, I think that is perfectly true. They were taken in 1949, and I think it is fair to say that they were taken under conditions which do not quite obtain now. They were taken under the almost chaotic conditions that existed at the end of 1948 and the beginning of 1949.

3149. *Chairman*: It would be very surprising if, after nine or ten years, at least some timings in a complicated profession like yours had not changed. It would mean complete stagnation.—Yes.

3150. *Sir Hugh Watson*: Can we look at your paragraphs 64 and 65? This is a bit that we particularly want to understand, because the Commission finds it difficult to appreciate your position about this matter. Your Association say, as I understand it, that because there is a shortage of dentists at present the first Spens recommendation is irrelevant at the present time.—Yes.

3151. That depends to some extent on what you mean by demand.—Yes.

3152. Because it is apparent, as we have seen that a number of factors affect that. Is the demand to be related to the total amount of work which ought properly to be done, or the amount of work which, under the social and financial conditions prevailing at the present time, the patients ask dentists to do?—I am not quite sure whether the latter position arises. You are suggesting that patients go for partial treatment?

3153. Not really. I think what I am really suggesting is the difference between need and demand.—We accept the difference between need and demand. Need is much greater than demand, but demand has risen very considerably since the introduction of the Health Service.

3154. But still you cannot say that the demand is the total amount of work which ought properly to be done?—I do not think we could in 100 years ever create enough dentists to do all the work that ought to be done. There is always bound to be a considerable difference between the two.

3155. And, of course, demand, as we have seen in the discussions we have had already this morning, is considerably influenced by the Government's policy in relation to the assistance provided for the dental service?—Yes.

3156. Would you agree, Mr. Balding, that the question of whether or not the first Spens recommendation is likely to apply in the near future, is determined not only by the amount of dental work which ideally ought to be done, but by the Government policy in relation to the dental service?—Yes, I think it must be. The Government can obviously fluctuate the demand rate by all sorts of devices, and they have done so in the past. If the Government were tomorrow to say that instead of paying £1 for treatment the patients would pay the first £5, quite obviously they would artificially cut the demand rate. One cannot deny that fact.

3157. If the Government decide, as you say, that half the cost of dentistry has to be paid by the patient, it is conceivable there might be sufficient dentists to meet the demand?—Yes.

3158. In these circumstances, this Spens recommendation might be relevant?—It might, Sir, as long as that particular Government remained in existence, of course!

3159. The first Spens recommendation, as you know very well, is based on the premise that there were sufficient dental practitioners, in relation to the demand for their services.—Yes.

3160. The Spens Committee said that to secure a spread of incomes comparable to that of 1938, arrangements should be made to ensure these proportions.—Yes.

3161. That situation could come about, Mr. Balding, could it not?—Yes, it is possible. Of course, at the time the Spens Committee was sitting, the Health Bill had become an Act, and it was known at that time that treatment, dentures and everything were to be free of charge. These recommendations were given under the circumstances of the law as it then stood, when a completely comprehensive service for everybody was just about to be introduced.

3162. You are saying that is what Spens had in contemplation?—Those are the circumstances under which Spens reported, and I agree with you that the demand rate can be fluctuated artificially, according to the particular Government which is in power.

3163. Your point at the moment is that Spens had in view a dental service which would be entirely free?—I have no idea what Spens had in view. I was pointing out that at the time he reported that was the law as it stood, and I would agree that any Government can artificially manipulate the demand rate by increasing or decreasing charges or doing anything else in that way.

3164. And if they did do that, then Spens recommendation No. 1 would immediately come into view?—It might do, Sir.—Mr. Cocker: I think on the Spens Committee we framed this recommendation, largely because of the existing shortage in numbers. I think we were influenced by the fact that we knew quite well that there were not enough people to do the work, if everybody demanded what they should have, and I think that influenced us in making that point.

3165. *Chairman*: I have never been quite clear about what the difference between Spens recommendation No. 1 and No. 2 really was intended to amount to.—It was this. You see, firstly, we had to provide, shall we say, a scaffolding on which a scale of fees could be worked out,

It is not so easy to get that scaffolding from a series of figures as from a single figure. It was quite clear to us, as I say that there just were not the people to do the work, and as everybody would be doing as much as he possibly could, taking the average all round it would be a fixed figure; otherwise, the Government may have felt that when this thing was put into operation graduated scales of income would be operated. It certainly would not have operated under these circumstances, because of this shortage.—*Mr. Balding*: Is it not a question, Sir, of the second recommendation being under conditions that are popularly known now as full employment? If the whole of the profession is going to be fully employed, then the second recommendation takes effect. If the profession is going to be under-employed, so that there is a spread of incomes, then the first recommendation takes effect.

Sir Hugh Watson: Yes, I agree. I think that is quite right.

3166. *Mr. Gunlake*: Of course, in the old days before the Health Service the dental practitioner in private practice had to take what came. The public demand was what it was, and he did the best he could, as others of us in other professions now have to do. The position now is that the Government not only controls the item of service payment, but it controls the amount of work to be done. Would it be a fair inference to say that it is your position, that any system of remuneration in the future for the dental profession would not be fair and proper unless it were also related to the volume of work—that the two things must be linked together?—I think so, Sir.

3167. *Chairman*: *Mr. Balding*, you have construed the second Spens recommendation as relating to a period of full employment for dentists. The recommendation with regard to general medical practitioners, I presume, also implied very nearly full employment, if not full employment. The doctors have not been under-employed, as far as we have heard, or were not thought to be at that time.—It is a little bit difficult to answer that, because the medical system of remuneration, of course, is quite different from ours. But would it not be fair to say that, if all the doctors had 2,500 or 3,000 patients on their lists—the maximum number of patients on their lists—

then not only would they all be completely fully employed in theory but, of course, their remuneration would be very much higher? The central pool, and so on, would be very much higher than it is at present. That is the position with dentistry, that at the moment the dentists are all within reason, fully employed, and when I say "all", obviously somebody of 65 cannot be quite so busy as somebody of 25. He just cannot physically do it. But there is no doubt that the dental profession is completely and fully employed. I am not suggesting the doctors are wasting their time, but I would suggest a comparable position with the doctors is when every doctor has the maximum number of patients on his list.

3168. Yes, but there are a number of figures quoted in the Spens report, and I have never been quite certain how they fit in one with the other. The Spens G.P. average figure for the doctors as a whole was £1,111; the Spens figure given for a single-handed practitioner working full-time was £1,800. We know there is an assumed relationship between the G.P.'s £1,800 and the dentist's £1,600, based on the latter not having 24 hours risk of the patient, but I have not found a similar relationship between the average doctor's £1,111 and what the Spens recommendation was meant to give the average dentist. If it is there, I have not seen it calculated in that way.—We have never, Sir—and I would like to make this clear—discussed the first Spens recommendation or any implications of it with the Ministry of Health. From the very outset the Ministry have accepted that the second Spens recommendation was the one to apply, and they did so in the original scale of fees. The first recommendation in its tie-up with the medical profession or anything else has literally, so far as I am aware, never been discussed with the Ministry of Health. Consequently we are not really in a position to give you very deeply considered opinions on this, because as far as we are concerned, and as far as the Ministry are concerned, for the moment it has not been worth worrying about. We have had quite enough to do to manage the scales of fees on the £1,600 basis. So that I cannot quite answer the question you put about the £1,111 for the medical profession and how it tied up. We have never gone into it.

3169. There is, presumably, a relationship between the £1,111, which was the average for all G.P.'s from the time of leaving their first house posts to the time of retirement, and the lifelong average for dentists, and the implication was that the £1,800 represented pretty full-time work for a doctor within that kind of service.—Is not what I said just now true, that it is an average remuneration, which is not based on the maximum number on everybody's list? If it were so, then the doctors' figure would be much higher, Sir.—*Mr. Cocker*: On page 10 of the Spens report the income of the doctor and the income of the dentist is compared, and in the succeeding paragraphs some of the reasons why there should be a difference between the two are set out. It is right at the end of the report.

3170. *Sir Hugh Watson*: It is in paragraph 30 which, as you know, refers to the relativity between £1,600 and £1,800. Paragraph 30 does not refer to the relativity between £1,111 and any other comparable dental figure, but of course Mr. Balding is perfectly right in saying that the doctor's £1,111 is the average income of the doctor, and it is not the income of doctors in receipt of fees from the maximum number of capitation grants available to them.—*Mr. Balding*: I think, Sir, with respect that the second line of paragraph 30 of the Spens report says that £1,600 represents full but not abnormally heavy work. The position at the moment in the dental profession is not only that it is fully employed, but it is doing abnormally heavy work, whereas, the criterion which it was measured against with the medical profession is the normal average work, that is, the average income and not the target income for each individual practitioner.

3171. *Chairman*: But taking the prospects of the two professions as a whole, and looking at the recruitment position, you would feel that you would not expect any very large difference between the expectations of what the student going into the one would on the average be likely to earn, compared with what the student going into the other would earn, after allowing for the points set out in paragraph 30? Is that right Mr. Balding?—Yes, I think it would be, if there were normal conditions in both professions.

3172. If, on the other hand, the conditions were very abnormal, so that one

profession was very much over-staffed and the other was very much under-staffed, you would expect recruitment to go so far that it would, in fact, swing the balance the other way?—It could do so, yes. I think that is, within limits, the relative position of the two professions now. I do not want to say anything about the medical profession except that I understood that they had a Committee to restrict, in some way, entry into the medical profession, whereas we have a Committee to encourage entry into the dental profession. That is the essential difference between the two, Sir.

3173. *Professor Jewkes*: Suppose that we take things as they are, and let us assume in the next two or three years that conditions will fall out as we expect, would you be quite happy at the thought that the average earnings in dentistry would be about £200 less than the average earnings of the general practitioners?—That all depends, Sir, on the report of this Commission, and how high it is going to set the income of the general dental practitioner.

3174. Let us leave out absolute levels. I am thinking of relativities now.—We have not quarrelled with the Spens Report, as regards differentiation between the two under normal conditions. I think that is a fair answer.—*Mr. Cocker*: I should say that the dental representatives on the Spens Committee were very strong on this, and we did our best, so far as I can remember, to try and persuade the other members of the Committee that the incomes should be the same. I think we felt that and felt it strongly, and still feel it.

3175. But you were not successful in that?—No. The other members of the Committee outweighed us near the end, and we wanted to get the thing finished so we accepted it, but for three solid days we fought that one.

3176. *Mr. Watson*: Was that for the same hours?—You could not exactly get the same hours, because the work is so different. The doctor sets off on his round, he goes to Mrs. Jones, and then he has to meet Mrs. Smith, and Mrs. Smith is probably five minutes away, so they are not quite comparable. The dentist is working absolutely all-in the whole time, and to that extent the dentist would require shorter hours;

otherwise this strain factor would become much more effective than it ought to be. So you could not quite compare them. We considered the medical hours of 50-55 hours a week, which included the time spent in going to and fro, and it was believed by the Spens Committee that the strain on doctors in performing those extra hours was no greater than the intensive strain which dentists have in a much less number of hours.

3177. *Sir Hugh Watson*: Mr. Balding, I would like to ask you this question. Under the second Spens recommendation, it was contemplated that 33 chair-side hours a week would produce £1,600 a year. How many hours per week would be required of dentists, in the circumstances contemplated in the first recommendation?—*Mr. Balding*: Again, Sir, I do not want to appear to be difficult, but I am bound to say that we have never considered this. We have not discussed it with the Ministry, even as to how many hours it would represent, or anything.

3178. *Chairman*: I think we would like you to do so, Mr. Balding. We would like to know how much in excess of what you would think is the normal amount of work for dentists they are now being called upon to do, because I presume you are really wanting to get to the state when dentists are not overstrained and overworked?—*Yes*. I thought you were asking me to put a sort of hours basis into the first recommendation of Spens.

3179. *Yes*.—I think, Sir, that whether it is under the first recommendation or the second recommendation, the recommendation as regards chairside hours in Spens remains, does it not.

3180. You feel that that is what would be the normal, average hours that you would expect under the No. 1 recommendation?—I think, Sir, that the question of hours, surely, is not tied up in the Spens Report with either recommendation.

3181. *Sir Hugh Watson*: With respect, it seems to me that in effect what Spens said was that 33 hours per week was a reasonable time for a dentist to work, except that in certain cases he might conceivably work a little more.—*Yes*.

3182. And if he did that, he would earn £1,600 a year. But I do not think, as far as I know, that Spens really applied the 33 chairside hours a week to recommendation No. 1, because obviously it would not require 33 chairside hours a week, on the present timings, to produce the remuneration contemplated in Spens recommendation No. 1, would it?—*No*, Sir, I imagine it would not. I find myself in some considerable difficulty, Sir, in answering these questions about No. 1 recommendation rather off the cuff. I would prefer, if you really want our considered opinion as to the implications of Spens recommendation No. 1, to take this back and let you have it in due course. We have never considered it, we have never been asked by the Ministry to consider it, and it was only, I think, on the 12th March, or something like that, that we had your letter to say that you would be pressing this point. Our policy is not decided by the two or three of us who sit at this table; we have Committees, the General Dental Services Committee and so on, which consider these things. We have not had time since we had that letter of yours, and I would like to be allowed to take this back and let you have a considered opinion.

Chairman: Certainly. We would like a considered opinion on this, because you will appreciate that one of our terms of reference does relate to other professions, and one of the other professions, which obviously has most connection with the dental profession, is the medical profession and we must take that somewhat into account. Perhaps that might be a convenient point to stop, and I think we might resume at 2.30 p.m.

(The proceedings were adjourned for lunch.)

On resumption

3183. *Chairman*: Before lunch, Mr. Balding, we were talking about the relativities in this particular series of figures mentioned in the Spens report, some of which seemed a bit incompatible. We do attach quite a lot of importance to them, but we will not pursue the question now, unless you wish to, because you were going to give us a more considered opinion of what you thought would be the position if what we are calling Spens No. 1 recommendation had

been applied. Is that all right with you?
—*Mr. Balding*: Yes.

Chairman: Then I think we will pass straight on to Sir Hugh's next point.

3184. *Sir Hugh Watson*: Mr. Balding, could we then pass to Spens recommendation No. 2?—Yes.

3185. You are very familiar with the expression in the Spens report, "We leave to others the problem of the necessary adjustment to present conditions". You notice that is as far as Spens went?—Yes.

3186. Spens never went any further than the present conditions, that is to say, the conditions obtaining at the time when he made this report.—Yes. Of course, the Spens remit did cover the future, did it not?

3187. I am aware of that. The remit to Spens was to consider this "with due regard to what had been the normal financial expectations of general dental practice in the past, and to the desirability of maintaining in the future..." But Spens dealt with it in the way that I have just indicated. That leads me to ask you this question. Do you consider that that formula for Spens was intended to refer, not only to the basis on which the profession would enter the National Health Service, but also to govern their remuneration so long as they remained in the service?—Yes, Sir, within limits, I think so. I think it must be taken to tie up with those words that you have just quoted about "the desirability of maintaining in the future the proper social and economic status of general dental practice, and its power to attract a suitable type of recruit to the profession." I think quite clearly, Sir, if Spens was making a recommendation of £1,600 in 1939 values, and then expected that to be translated once and for all into 1948 values, and that was the end of his remit, then I do not think he was fulfilling the original part of the remit. Therefore, I cannot think that that was in their minds at all, and that they did intend that it should be kept under review from time to time, in accordance with the operation of economic and other circumstances that arise.

3188. That may well be what he had in mind, but he did not say so, did he?
—I should have thought it was inherent, Sir, that if you are going to take

the view that this was a once and for all adjudication, that the £1,600 was going to be once and for all translated into 1948 money, then I should have thought you were implying, or anyone who took that view was implying, that Spens took an extremely narrow view of his remit. With respect I would say it is being a little bit unfair to the Spens Committee to expect them only to take that very narrow view.

3189. One does not want in any way to be unfair to the Spens Committee, but about that time it was apparent to Sir Will Spens and his colleagues that they were dealing with something in the future of which they knew very little. They did not know anything about how the Health Service was going to work in practice, and it would be understandable, would it not, that, in these circumstances and in that state of knowledge, they should confine themselves to laying down a basis for condition of entry into the National Health Service?—I think that their remit goes far beyond the question...

3190. I agree the remit does. I agree with you, of course that the remit mentions the future, but what the Spens Committee said was, "We leave to others the problem of the necessary adjustment to present conditions". That is all that Spens said?—Yes, Sir, except that Spens could have obtained evidence, surely, on the pure question of money values, the difference between 1939 and 1948, and he could have framed his recommendations in terms of 1948 money.

3191. Yes, but you see, with great deference to Mr. Cocker who is present and who was on the Committee, Spens did not think he was qualified to do that. That is what he said. Therefore, he said, "We leave to others..."?—*Mr. Cocker*: I do not think we were necessarily wedded to the idea that that was the end of it. I mean, it was perfectly clear that you would get variations in the value of money, and if the Spens report was to be of any use it must have some reference to the future, and it used the word future.

3192. Yes, I know, but you see I am a lawyer, and I am accustomed to construing documents as I find them, and my education, such as it is, tells me that I am not entitled to look behind the document. What I am trying to find

out is what anybody is reasonably entitled to deduce from this document itself?—*Mr. Balding*: I would have said that if you read the remit, where it says "... after obtaining whatever information and evidence we thought fit, what ought to be the range of total professional income of a registered dental practitioner in any publicly organised service ..." the only possible interpretation that could have been put upon that was that there was going to be a service, it was going to be a continuing service, and it would be quite useless for Spens to have said, "We do not know what is going to happen in the future, but at the beginning of this service in 1948 we think dentists ought to be paid £X." I would suggest that if they had produced a report on those lines they would not have been fulfilling their remit, and they would not have been carrying out the duty that was entrusted to them; whereas, in order to get over that, they put values in terms of 1939 which was a fixed value which everyone knew, and they left it to others to adjust it according to circumstances of the service. But the service is a continuing service, and they were not asked to say what was the income at the beginning of this service.

3193. Yes, but I must remind you that what Spens said was, "We leave to others the problem of the necessary adjustment to present conditions." He never went any further. He never suggested any machinery for review, and is it not precisely because of that that the Danckwerts adjudication was necessary in the medical profession?—It is because, if you like, the Minister took that view of the Spens remit that the Danckwerts award became necessary, and indeed, with respect, the setting up of this Royal Commission.

3194. Yes, indeed, but you see it is, at least, an intelligible view, is it not?—It is one interpretation of it.

3195. It is an intelligible view that, after a settlement based on the Spens recommendations had been reached, any subsequent revision of the remuneration of doctors and dentists should be determined in the light of all relevant circumstances. Spens provided the terms of entry, and for the rest the matter would have to be reviewed. Is not the real trouble because nobody thought of setting up any machinery to do that beyond Danckwerts, which was only an ad

hoc remit?—Yes, but again, I would suggest that Spens was not specifically asked to determine the point of entry of the two professions. His remit was undoubtedly very much wider than that.

3196. He was asked, in point of fact, to consider, "what ought to be the range of total professional income of a registered dental practitioner in any publicly organised service of general dental practice".—Yes.

3197. In doing so, he was asked to have certain things in view, I agree with you, but that was his precise remit, and that is what, in fact, he did.—Yes, but I am suggesting, Sir, that you can interpret that in two ways; one in the narrow way that he was asked to say what they should come in at, and the other was that, having regard to the fact that it was a continuing service, he was asked to say how they should fit into the general picture.

3198. All that he said about that matter, as you know, was that any adjustment should have direct regard not only to estimates of the change in the value of money, but to the increases which have, in fact, taken place since 1939 in incomes in other professions.—It would seem, Sir, that there are various interpretations that can be placed both on the Spens remit and on the Spens report, and we take the view that the Spens report was not presented in the narrowest sense, but that it was meant to be the foundation on which the remuneration of a profession in a continuing health service should be based, that is to say, on 1939 values of money. Otherwise, we cannot see why Spens did not report in 1948 values.

3199. Spens did not report in 1948 values. I think it is clear, Mr. Balding, that he did not feel he was qualified to do so. He was not an economist.—He could have taken advice on it, could he not?

3200. That is what he said.—Figures were undoubtedly available as to the difference in values of money between 1939 and 1948, and we cannot help feeling that, had he felt that it was his job just to say, "This Health Service should start, and dentists should be paid £X and doctors should be paid £Y" he would have said so.

3201. But you see, Mr. Balding, the Spens report says in paragraph 7: "We

were not qualified to form an opinion on the adjustment of pre-war incomes that would be required to produce corresponding incomes today." So the Spens Committee never addressed themselves to that problem. What they said was simply, "We leave to others the problem of the necessary adjustment to present conditions."—*Mr. Cocker*: Is it not a fact that the medical profession are taking the same view of their document, as we are taking of ours?

3202. I quite agree. I had the same conversation, with a representative of that profession, as I am having with Mr. Balding now.—It is a little difficult to understand that two professions should enter into contractual obligations with the Government, believing that a certain thing would happen, if there was not some substance for their belief.

3203. With great respect, that does not follow. It could have been that their belief was wrong. As Mr. Balding says, very reasonably, it is apparent that there is more than one possible construction of the Spens Report, and what I am trying to suggest now is that one apparently reasonable construction is that the Spens Report was intended to be only a measure of the conditions in regard to remuneration on which the profession would enter the National Health Service. What is to come, if you like, was still unsure.—*Mr. Balding*: I think that we are dealing with paragraph 7, but the recommendation is much more specific. In paragraph 32 (2) Spens says quite definitely that a dentist should receive, "in terms of the 1939 value of money, a net annual income of £1,600." That is just my point, that it is specifically tied to 1939. Had he wished to tie it to 1948—in other words, had he been making a report only on the conditions under which the profession should have entered the service—he would have given it in 1948 money, but because he realised that there was a period of inflation setting in he tied it to 1939, and he said that, whatever happens, the profession should receive that in terms of 1939 money.

3204. That is quite clear.—Does that not slightly, if I may say so, contradict the possible interpretation of paragraph 7?

Sir Hugh Watson: I think it does, Mr. Balding. You have been very fair with me, and I think I have got to admit that

it does. It has a slightly different outlook from the phrase beginning "We leave to others . . ."

3205. *Mr. Gunlake*: Do you think the reason why the Spens Committee said nothing very much about the continually declining pound, was that they hoped, like most of us, that the Government would not allow it to decline?—Yes. I would agree that they were placed in an extraordinarily difficult position, and I think it is quite fair to say that they might have had some difficulty in producing satisfactory evidence to translate that into 1948 terms. I am afraid this way of saying, "We leave to others . . ." is just one of the unfortunate legacies of the Spens Committee.

3206. *Professor Jewkes*: We have the advantage of having Mr. Cocker with us today, and after all he was on this Spens Committee. I wonder if he would tell us whether, in fact, there were any discussions on the Spens Committee about the possibility of the value of money falling, or whether that was never talked about?

Chairman: That is a long time ago, Mr. Cocker.—*Mr. Cocker*: I think there is little doubt about it that we had in our minds the variation in the value of money. I do not think there is any question about it, or we should certainly not have reported in the terms we did. It is a fact that Sir William Spens did not see fit to put it into 1948 terms, but I think there is little doubt about it that, in our discussions, we certainly gave a good deal of thought to the question of what was the value of money at the particular time we were catering for.

3207. *Professor Jewkes*: When you used the phrase, "We leave to others . . .", you had clearly in your mind that there were such others, and that their function would be to watch the changes in the value of money, and adjust dentists' earnings in conformity?—Yes.

3208. *Mr. Bonham-Carter*: How confident do you feel about that? Would there be some truth in the suggestion that at that time inflation was not a word which occurred in every line of every newspaper, and, in fact, there did not appear at that time to be a great deal of need to think about it?—There is some substance in what you say, but taking the broad view I do not see how

we could rule it out. No body of persons could forecast what was going to happen in the future, and therefore if we had to make provision, we had to make provision for the future to some extent.

3209. *Chairman*: Mr. Balding, we have, as you know, seen other medical bodies, and we have been told by some that they consider that the proper adjustment would keep them in line with other people of a similar sort of standing, but other people's remuneration in that sort of bracket is not affected by the Government directly. On the other hand, we have one body which has put to us that they reckon that Spens provided them with a complete safeguard in that they should have either the change in the value of money, whatever that may mean, or an adjustment to take into account increases in similar professions, whichever is the greater. Which school would you subscribe to?—*Mr. Balding*: Generally, the changes in the value of money would surely have brought about rises in incomes of other professions to a certain extent. I do not think we would claim for one minute that the dental profession expects to be entirely cushioned automatically against inflation or any rise in the cost of living, but we do feel that, at least, Spens means that from time to time there should be a review of the situation, so that we retain approximately our proper status in the income levels.

3210. That is rather what I thought, and of course there is no fixed and permanent status as Spens implied—in his first recommendation, anyway—that you had been relatively, as a profession, paid too low before the war.—*Yes*.

3211. And I take it that, for that reason alone, you would never expect complete fixity of status, and a completely static society?—*No, Sir*, as long as we keep our place among the professions, as we know it today.

3212. *Sir Hugh Watson*: To come back to this difficult question, Mr. Baldwin, you are aware of the terms of the remit to this Royal Commission?—*Mr. Balding*: *Yes*.

3213. And you are aware that we are not by the remit specifically required to consider the Spens Report, although we have said in a public statement that we will consider, among other things, the Spens Report.—*Yes*.

3214. And you have just explained to the Chairman that you would not claim that the dental profession should be insulated against the cost of living.—*No, not completely insulated. I think that is unreasonable.*

3215. I do not know if this is the proper time for you to deal with this. It is rather difficult to decide what is the right time to raise all these questions which are so closely inter-related, but in your memorandum in paragraph 127 your Association "trust that the Royal Commission will be disposed to support the opinion of the Association that the remuneration of general dental practitioners in the National Health Service should be increased by the institution of a scale of fees designed to produce for the hours of work recommended by the Spens Committee £3,200 net per annum." That is not the logical outcome of Spens today, is it?—*Do you suggest it is rather too modest?* It is not an extravagant claim at all, as we have said down below, *Sir*. It is not based on price levels and the fall in the value of money since 1939.—

3216. You have been very frank with me. What I really want to know is this. In making that claim there, which you say is a reasonable claim, are you saying in effect that you do not pretend to follow Spens today to its logical conclusion, because if you were, you see, you would want to multiply £1,600 by 2.7?—*Yes, Sir*, I would agree with you entirely. We have tried to make a claim that is reasonable in all the circumstances for the dental profession to make, and not just one purely based on arithmetical figures and the fall in the cost of living, which might make the claim appear quite fantastic.

3217. In other words, in your view, a body such as this Royal Commission inquiring into this matter today ought to have direct regard to the value of money and to the increases which have taken place in the incomes of other professions—in fact to both these circumstances?—*Yes*.

3218. In fact, in the words of paragraph (a) of the remit to the Royal Commission?—*Yes*.

3219. *Mr. Gunlake*: You know, of course, that your medical brothers are claiming what you describe as an arithmetical adjustment of Spens by

multiplying by 2.7?—I did hear some of the evidence that was given, but I must admit that I got a bit fogged. I do not pretend to be a mathematician, and I am not quite clear exactly what the medical profession are claiming from the mathematical point of view.

3220. *Chairman*: We do not want to ask you about your views on what other people are claiming.—I am very relieved about that.

3221. In the same way on the Spens matters, we do not want to put Mr. Cocker, who happened to be a member of the Spens Committee, in any difficult position by asking him questions about what happened then.—But I think the answer is that we have not based this claim purely on mathematics.

3222. I would like to ask a question or two on distribution, Mr. Balding. You remember table C in Spens which showed what he thought the distribution would be under his scheme No. 1, which showed even then a considerably greater increase for the people who were earning very little before the war, than for those who were earning rather more. I wondered whether you felt that that sort of spread was still what you would like to see in general circumstances. You see, you have since, I gather, got round to a time when there is a much greater concentration of incomes round one figure nearer the top.—Yes, Sir. May I suggest with respect that this question is very much tied up with the No. 1 recommendation, is it not?

3223. It is a bit, yes.—Spens did say, in paragraph 18, I think, that for a time he reckoned that quite a considerable number of incomes would be concentrated round about the £1,600 figure. If you are asking me to comment on table C I would prefer to tie that up with our comments that we will send you on recommendation No. 1.

Chairman: Very well.

3224. *Professor Jewkes*: Mr. Balding, you have already made clear to us, in relation to paragraph 127 of your memorandum, that you are not really trying to apply, in any strict mathematical way, what you believe to be the Spens recommendations. But in paragraph 127 you take the famous £1,600 a year, add 100 per cent. to it and you get £3,200 net. That is one way of stating your claim, but in the actual

claim as you submitted it to the Minister of Health on the 12th February you say, "The claim is, therefore, that the net remuneration of general dental practitioners should be increased by at least 24 per cent., to offset the devalued purchasing power..." The 24 per cent. would, perhaps, be 29 per cent. now, but we will leave that on one side. That means you are really putting a claim in the form of present day remuneration, plus 29 per cent.—Yes.

3225. We have got the claim presented in two ways, and they do not amount to the same thing. Which is the form of the claim, as it stands now?—There is no doubt at all in our minds about that. That was a claim submitted to the Ministry of Health. I think I am right in saying it has not been submitted as a claim to this Royal Commission by us. It may have been handed on by the Ministry of Health. After we had had discussions with you soon after you were set up, and found that you were prepared to consider the whole thing *de novo*, taking into account Spens and everything else, we then prepared this memorandum which is the basis of what we are putting before you as a Royal Commission, not the claim that we put before the Ministry. There is a very good reason for that, which is based on the long history of dental remuneration, which I would like to say something about at some stage, Sir, but perhaps this is not the proper time.

Chairman: We will come to that.

3226. *Professor Jewkes*: So we can put on one side what you call the claim, and simply confine ourselves to paragraph 127 of your memorandum?—Yes.

3227. *Chairman*: I have one more question on Spens—on paragraph 23, relating to the hospital side. You are dealing with that separately, I know, but in that paragraph it says: "In so far as... dental specialists have had a professional training comparable to that of medical specialists and have obtained a higher qualification comparable to those obtained by medical specialists, they ought in our opinion to be remunerated within the same range as medical specialists." I take it that would still be broadly your view?—Very definitely, yes.

3228. I thought, probably, that was as far as you wished to go on that subject

at this time, because you have remitted it to the Joint Consultants Committee? —Yes. I think I did say we do not feel competent to speak for the dental specialists, but we do at the same time ask that they should be on a parity with medical specialists. We must leave it to the Joint Committee to present evidence on behalf of both professions at the same time, as regards specialists.

3229. *Sir Hugh Watson*: You mentioned a moment ago that you did want to talk about the history of dental remuneration. I had half thought that perhaps we did not need to go into that, because in 1955 you did make an agreement. Do you want to go into all that went behind that agreement?—Indeed, Sir, otherwise I think we might perhaps give quite the wrong impression.

3230. *Chairman*: How far back do you want to go?—I want to go back to the 24th May, 1948.

Chairman: Just as far as that? I wondered whether you wanted to cover what was happening before.

3231. *Sir Hugh Watson*: I forget whether the Chairman said it in his opening here today, but he generally says that we have read your memorandum, and we have read all the statements in it. You do deal with these matters fairly fully in the memorandum, but if you want to elaborate, Mr. Balding, please do.—Yes, Sir. We tried to draw this document up in a reasonable way, but as you have mentioned the 1955 agreement, from which certain deductions might be drawn—namely, that we were satisfied with the remuneration up to 1955 or, alternatively, that we were satisfied with the agreement then—I would suggest that we must go right back to the beginning, in order to put you really into the picture of the conditions under which that 1955 agreement was accepted; because it was accepted and we submit it has been carried out by the profession.

3232. You make it quite plain in your paragraph 90, that you entered into the agreement because you could see no practical alternative.—Exactly. That is so, Sir, but if I might, perhaps, give an analogy, there have been cases where tenants of property have found themselves in a position where they had to accept certain conditions and certain terms, and have, in fact, signed the lease for that property. Subsequently Rent

Tribunals and other things have been set up, and they felt themselves perfectly justified in putting the whole case before the Rent Tribunal. Now, Sir, with the greatest respect that is how we regard this Royal Commission—that we have entered into these agreements under a certain amount of duress in the past and, in fact, dental negotiations have never taken place other than under conditions of duress, and we do feel that we would not be doing our duty if we did not put before you the whole picture of dental negotiations from the beginning.

3233. *Chairman*: Much of it is here, but there are certain points which you want to supplement. I think one particular point, since you wish to raise it, is that we would like to know the extent to which, for instance, your items (c) and (d) in paragraph 74 were the result of negotiation or consultation. I am referring to the point about confiscation of fees and the extent to which that was preceded by discussion, consultation, justification or whatever it may be.—I take it you are raising that, because it is a particularly important point. But if I may I would like to go back to the 24th May. In actual fact, I suppose the date should be 10th May, 1948, which is the date which appears on the Spens Report, Sir. That report was dated 10th May, and it was published, I think, on the 18th or 19th May; it was received by us on the 20th May, and we had to start negotiations with the Department on the 24th May. We had four days to consider that Spens Report.

3234. And you, personally, were in on this?—I personally was there Sir. When we started on the 24th May, which was a Monday, we were informed that the Minister had not even yet accepted the Spens Report, and that he would make a statement in the House on the Thursday of that week, the 27th. Meanwhile, we were to go ahead formulating a scale of fees, on the basis of the second Spens recommendation. We were further told that negotiations had to finish by the 4th June—that was on the following Friday week—and so we had 12 days to carry out the entire negotiations for the scale of fees. As you will appreciate it took two years in 1955 to do a rather less task. That was my point about negotiating under duress. There was just no time to do anything

but just get down to figures; if we disagreed we disagreed, but there was no time to compose any differences that we might have had with the Department. Amongst other things, of course, there was the imposition, as we considered it, of the betterment factor of 20 per cent., about which there was no time to argue. We were told that the medical profession had had the 20 per cent. betterment factor, that we should get the same, and if the medicals got more we should get more, but there was no question of arguing about it—that was the proposition. We did meet, Sir. We met Monday, Tuesday and Wednesday of that week. On Thursday the Minister announced the acceptance of Spens on which we had already negotiated for three days. We met again on the Sunday and Monday, and the following Friday it was all finished. The regulations were laid on the 17th June, and the service came into operation on the 5th July.

The first thing we had done was to ask for a postponement of the appointed day, as regards dentistry. The Act of 1946 does allow the Minister to bring in separate parts of the Act on separate days, and we said that the time was so short we could not negotiate a proper scale of fees in 12 days. We asked if there could be a postponement of the appointed day, and not unexpectedly it was refused, of course. But those are the conditions of duress which were imposed by the time limit on the original scale of fees. So to be fair, Sir, we did try, and the Department tried with us, to work out something on a time basis, on an expense ratio and on everything. We considered the time was quite inadequate, but there was just nothing which could be done about it, Sir, and the scale of fees was not accepted formally by the profession. We had done our best within that time to formulate a scale of fees, but we did not feel that we could give it our blessing on behalf of the profession.

3235. There was no pool of experience at that time, on which you could base a detailed scale, or not very much experience?—No, Sir. There were a large number of factors which were missing, about which we had to supply information; amongst them was the question of expense ratios, and I think the information we supplied turned out to be reasonably accurate. As regards

the timing of operations, that also was supplied by the profession and there again, as regards the individual operations, the Penman Committee, with one or two exceptions, largely justified those timings. So that it is quite fair to say that we did our very best to co-operate in those 12 days, but 12 days is quite an inadequate time to do a task of that magnitude.

3236. *Mr. Gunlake*: Why do you say your request to postpone the appointed day as regards dentistry was "not unexpectedly" refused? Was it so unreasonable a request?—No, we did not think so.

3237. Neither do I.—I think if you cast your mind back to the situation then it would have been difficult for any Minister of Health to admit at the beginning of June that he was in such a state of unpreparedness that he could not introduce this terrifically publicised National Health Service altogether on 5th July. I do not think any Minister of Health could really have stood up to that.

3238. You were over-borne by the weight of political pressure?—Exactly, yes.

3239. *Professor Jewkes*: You had 12 days to discuss the contents of the Spens Report, but had the profession before that had discussions as to the system of remuneration they were in favour of? Had they made up their minds before this that they wanted to be paid per operation or had they discussed other possible methods of payment?—The profession had discussed other possible methods of payment but it was not in a position to come to any concrete conclusions until it saw the Spens Report because we did not know what Spens was going to recommend at all. This was merely a carry over of the old National Health Insurance system translated into National Health Service conditions which meant a comprehensive service which the old service was not. That, Sir, was the position on 5th July.

3240. *Sir Hugh Watson*: Really, what you are saying is that by force of circumstances you and the Government in these months of May and June found yourselves in this position, that you have so fairly described to Mr. Gunlake, that the introduction of the Health Service for dentistry was imminent and some-

thing had to be done. The Spens Report was only then available although it was set up in June, 1946—it was not their fault they took all that time—and that was the situation with which everyone was confronted.—Yes. But from our point of view while we are not in a position to blame, and would not wish to blame anyone, there is the fact that we were not in a position to negotiate that original scale of fees as it should have been negotiated.

3241. *Chairman*: How many items does the scale of fees contain?—Somewhere about 30. Of course, some of them are sub-divided into four or five different sections.

3242. *Sir Hugh Watson*: Was there very much between you and the Ministry on any of these items?—On some of them, not unnaturally.

3243. Which?—One of the principal things was the question of the betterment factor.

3244. *Chairman*: Take these item by item, the relationship, if you like, between the items, disregarding the betterment factor.—I would say this, that we had to discuss these items and some of them involved a great deal of discussion; eventually if we came to a deadlock we would be inclined to pass on to the next thing because we had to get on—that was the position. There were quite a number of items on which there was a very fair measure of agreement but there were items where it just came almost to a deadlock. But as we had to get on we left it at that. Without looking up all my notes, which I have still got here, I would not like to say to how many that applied but it did apply to a certain number of rather important items.

3245. *Sir Hugh Watson*: At the end of the day did you feel, as the result of the shortness of time available, that the profession were unduly prejudiced?—Yes, I do not think there is any question about that because we were not enabled either to produce evidence or to say: "that is not acceptable". We just had not the opportunity to justify anything that was put forward. Either the Department accepted it or they did not. If they did not accept it we had no opportunity to say: "We will go away and come back next week and produce figures to support our view". We just

had to pass on. That was the state of affairs.

3246. You did say earlier today, and you do say in paragraph 75, that the Penman Committee substantiated almost *in toto* the timings which had been first assumed—that is in 1948.—Yes.

3247. What were you at issue about with the Ministry? Was it charges?—Yes. There were various factors that had to be assumed. There was the expense ratio. We settled on more or less agreed on an expense ratio that had to be sub-divided between what we refer to in this document, I think, as the fixed charges and the variable charges. There was a good bit of argument about that. There was a good bit of argument about the incidence of treatment which, of course, entered into it. There was a good bit of argument about individual fees, some of which were not purely on a time basis. There was a good deal of argument about what is known as the "skill" factor because Spens refers to the dentist with more than usual skill. The Department suggested that that only referred to the hospital service, but we suggested that it did not. There were plenty of individuals in private practice who had the requisite skill and, therefore we believed certain operations should have a skill factor. There was argument as to what that skill factor should be. There was argument as to whether if that skill factor was allowed something had to come off the rest of the scale of fees to pay for it. There were innumerable little points like that on which we could have argued for weeks at a time but we just had a fortnight to do the whole thing.

3248. Broadly speaking, as I understand it, the object of the exercise was this, was it? Spens gave you £1,600 a year, which I admit you knew only when the Spens Report was issued.—Yes.

3249. They gave you 33 chairside hours a week plus nine non-chairside hours, and you had a scale which produced just that.—Yes, but there was endless room for arguments as to how long an operation took.

3250. The Penman Report appears to confirm the timings which were agreed in 1948, is that not so?—Very largely, yes, but that was a year or 18 months later. Our job at that time was to convince the Department that those times were reasonable.

3251. You appear to have convinced them.—Yes, but it wasted a lot of time. We only had six all day meetings, including the Sunday, and you can waste an awful lot of time arguing about whether a particular operation takes 25 or 30 minutes. It may seem absurd but that five minutes made all the difference to the fee that was to be allocated for expenses and everything else, and it would make a considerable difference in the final arrangement of the fee. So that there was plenty to argue about I can assure you.—*Mr. Buchanan*: There were eight of us representing the British Dental Association and all of us had been in practice for at least 20 years. The overall figure available recommended by Spens was so many chairside hours and was divided up into units of five minutes. These units were allocated to each sort of dental operation and the eight B.D.A. representatives who battled this out had very divergent views. It sometimes took about two and a half hours to decide on one or two dental operations but eventually we did produce a time schedule in units, I think, of five minutes, which was something like —I am sorry I do not remember exactly —2s. 3d. It was sincerely and honestly done and there is no question but that the Association, and particularly Mr. Balding, were under tremendous pressure.

3252. *Chairman*: It would seem as though very good work in this untried field was done because Penman, 18 months later, found that in those 12 days you had arrived at about the right answers.—That was always in our minds.—*Mr. Balding*: That rather brings us on to your question about the original 50 per cent. cut above a certain figure and I think your question was whether there were any negotiations over that at all. Well, I think the short answer is quite definitely that there were not.

The history was that on 1st December, 1948, we were summoned to the Ministry and we were told that the Minister was worried about the returns coming in—the payments to dentists, and so on—and that he had got to act immediately. We were told that. We were not being asked to agree to this or that but to accept it. We put the question—I am referring to my notes taken at the time—"Are you going to impose an arbitrary ceiling without any discussion with the profession?", and the answer was that the Minister wanted to check this situation by 1st

January, 1949, and the regulations must be laid before Christmas. "It is not fair to ask you to consider this matter so quickly, it is the responsibility of the Minister". Those were the words used to us across the table and we were just told that that was what the Minister was going to do.

I was glad to hear you say, Sir, that you thought that the profession had done a fair job in those 12 days because not one word of that were we credited with when these regulations were introduced in the House. I think anyone looking back would appreciate that there was bound to have been a tremendous sudden demand, a big demand, for dentistry and that the Spens recommendations and the Spens timing would go by the board during that time. To reduce the earnings of the profession and try and hold them down to the strict Spens level and timing during that period of time when this terrific demand was taking place would seem to us quite unreasonable.

3253. *Sir Hugh Watson*: The bulk of the demand at that time was for dentures, was it not?—Yes.

3254. It was really that that was alarming the Minister, was it not?—It was the money that had not been estimated for, of course, in the original estimates. You will remember that we mention in the memorandum that the original estimate was £7 millions for the first nine months of the service but in actual fact it cost £18 millions. That was the Minister's trouble. On 17th February, 1949, there was a debate in the House on these supplementary estimates and we felt in view of what we had done to get the Health Service started that we received rather harsh treatment not only as regards this regulation that had been introduced on 1st February, 1949, but as regards the Minister's speech when he was justifying his under-estimate and when he said in the course of his speech:—

"Who would have said that by now even in the most obdurate of professions—I do not want to make too strong a statement—the profession whose ethical standards as a profession are not as high as they might be—the dental profession—we should have got 92 per cent. of the dentists in? As these people came into the Service naturally the expenditure went up."

We felt that was a fairly raw deal considering what we had put in to get the Health Service started and the conditions under which that scale of fees had been negotiated. We did not feel that the Minister was justified in referring to the profession like that or in cutting their remuneration in the way that was done. Two days later the Minister announced the setting up of the Penman Committee.

3255. *Chairman*: That was at the end of February?—Yes, February, 1949.

3256. May I just go back? Have I got the dates right? You said you were called on the 1st December, I think.—Yes.

3257. And the actual reduction came into force on the 1st February?—Yes.

3258. And the process was that on 1st December, or just after, you had a talk in which it was explained that there was nothing to negotiate. The Ministry were not going to land you with the responsibility but were going to do it, and then the Minister announced with a fair bit of warning to those affected that this was going to happen from 1st February, is that right?—Yes, I think that is it. Of course, our immediate reaction to this announcement was to point out how grossly unfair it was particularly with regard to the position obtaining at that time and which was bound to obtain at the beginning of a huge undertaking like this. There was then a considerable hold up in payments to dentists with the result that some dentists were two, three or four months behind in the payments that were owing to them. The operation of this regulation would have been such that virtually for their payments during that month they would have lost all their back payments. They would have come into the one month when this regulation was introduced and I think as a result of that the Minister postponed the operation of the regulation for a month. We were told that it had to be laid before Christmas. In actual fact it was laid as soon as Parliament reassembled after Christmas to come into operation on 1st February.

3259. He did postpone it because of the hardship that would have arisen through all these back payments coming in one month?—I imagine that was a factor that influenced him but we had no further discussions about it. We were just told that was what was going to happen. It did not actually happen as was

forecast at that meeting but it did happen a month later.

3260. At that time, what dentists were actually earning for one reason or another was a good deal more than had been anticipated?—Yes, I think so.

3261. *Mr. Gunlake*: You are aware of the third of our terms of reference on this Commission, are you?—Yes.

3262. Clearly, so long as your profession is remunerated on an item of service basis this question of the scale of fees is one that has always to be considered; hence our deep concern with the history of what has happened in the past in devising and amending the scales of fees. I would like to ask you two questions at this stage. You did refer in something you said just now to regulations being presented to the House. These are regulations made by the Minister, I presume, under powers conferred upon him in the 1946 Act and they are laid on the table of the House without debate?—Yes, without debate. A debate can only take place if there is a Prayer made to annul them which did in fact happen as regards this regulation; a considerable debate took place and the Prayer, of course, was withdrawn at the end so the regulation remained in force. But the regulations came into force on the date stated on the regulations which is not always the date they are laid. They may be laid a week or a fortnight before but they become law without any resolution of the House. They are automatically made law and the only thing to do is to annul them, and that is the only way they can be debated.

3263. My other question was, is the remuneration of the members of your profession borne on the Departmental Vote of the Ministry of Health?—I think it comes under the general National Health Service Vote.

3264. And that is a figure which is voted by the House and if it is exceeded there has to be a supplementary vote?—Yes, that is so.

3265. *Sir Hugh Watson*: While we are on that point, you read an excerpt from Hansard in which the Minister appeared to indicate surprise that 92 per cent. of the profession had come into the service. Do you remember what indication, if any, the profession gave to the Ministry of the proportion of dentists that might be expected to join this service?—I do

not think we gave him any idea as to the proportion but I do know we did point out to him at a meeting—I think it was held on 6th June, 1948, just before the Act started—that under the Spens formula the gross remuneration of the average dentist was in the neighbourhood of £4,000, that there were something over 10,000 dentists in active practise and that if he got 10,000 in the service the cost to the country would be £40 millions, which in fact it turned out to be a year later. That was when he was estimating at £7 millions for nine months; but we did not say that 10,000 dentists were coming in.

3266. You did not tell him that according to your expectation only 5,000 might come in?—No. We had no idea at all how many would come in.

3267. And he would probably have still less!—Yes, that is true. We did suggest at that time that £7 millions was in fact an underestimate and we put it to him if he was hoping to get them all in it was going to cost him £40 millions, and so in fact it turned out in the following years.

3268. *Chairman*: Your figure of £40 millions, that is the gross figure?—Yes, the gross.

3269. Meaning, roughly speaking, £20 millions net over 10,000 dentists, is that right?—No, Sir. The scale of fees as grossed up on the £1,600 and the 20 per cent. betterment factor made it £1,920 and that grossed up with the expenses makes it £4,000 exactly.

3270. It was based on the £1,920 per dentist coming in?—Yes, less the superannuation contribution.

3271. The £7 millions for nine months. I suppose, is about £9 million or £10 million for the full year. Was that based then on the same figure of £1,920 per dentist?—I imagine it could not have been. I am not quite sure when these estimates are introduced but I think that when a Bill is first published in a green book in Parliament they usually put a financial memorandum on the front of it. If that was done in the case of the Health Service—I really do not know—that would have been in 1945 or 1946.

3272. So it is an earlier estimate than yours?—Yes.

3273. We shall be seeing the Department later on.—How they arrived at

£7 millions I do not know, but I think it is fair to say it probably must have been a pre-Spens estimate. If that is so they worked it out quicker than we did—in working out the Spens formula we only had 12 days.

Then the Penman Committee was set up and again its setting-up depended entirely upon the co-operation of the profession. Not only did we nominate people to it but again we had to ask our members to fill in forms showing the timings of the various operations. And in the middle of that while the Penman Committee was getting going in April, 1949, we had an invitation from the Minister to discuss a new scale of fees. We felt that it was rather unreasonable to set up the Penman Committee to investigate the timings, expect us to co-operate and within two months expect us to discuss a new scale of fees. And so in fact we would not take part in those discussions with the Ministry. We said we felt the Minister should await the Penman Report. The Minister therefore produced what is now known as the 1949 scale of fees which we claim showed a reduction of 20 per cent. on the original scale. I think, Sir, in the factual memorandum that is before you from the Ministry they refer to that as a 17 per cent. reduction but I can only say that we have always regarded it as 20 per cent. Indeed, the Parliamentary Secretary, Mr. Blenkinsop, on the 15th May, 1950, said

"We made an overall cut of some 20 per cent. in effect" and the following year, in 1951, the Minister, Mr. Marquand, also said:

"In 1949 there was a 20 per cent. cut in dentists' remuneration."

So that for once we would support the Minister in claiming that was a 20 per cent. cut in spite of what appears in the factual memorandum.

3274. *Sir Hugh Watson*: Before you get too far forward, could I go back for a moment to the meeting on 1st December with the Ministry representatives when you were told what you told us a moment ago; did you forcibly protest against this action which was going to be taken?—Yes, Sir.

3275. You did not say that, as far as I remember, you know.—I am sorry.

3276. You said earlier you were at that time acting under duress and I think

the Commission would like to know how exactly you expressed yourselves when confronted with that situation.—I think, Sir, the answer is that we expressed ourselves in no uncertain terms. We pointed out to the Department that this was a quite exceptional condition—as was later on recognised in various debates that took place. Mr. Bevan, when he was no longer the Minister of Health, talked about taking in the hump of the dental population and working the hump off. We did not exactly put it in those terms but that was in effect what we said to the Department. We said in effect that it was grossly unfair to judge anything by what happens in just five months of the Health Service. The same applies to the introduction of any service of any description particularly when it is going to be for the first time in history a free service; there is bound to be a tremendous initial rush. We said that we thought that to introduce what we described then and there as a panic measure to deal with it was grossly unfair to the profession which was doing its best to meet a demand that had been thrust upon it willy-nilly. We could not do anything about it at all. There was nothing we could do about the regulation either.

3277. You took the only constitutional action open to you, you put in a Prayer to annul it?—A Prayer was put in by a Member of Parliament who happened to be a member of the dental profession.

3278. Which was the only constitutional step open to you?—Exactly, yes.

3279. I am sorry to have interrupted you.—I am sorry I did not make it clear.

3280. *Mr. Gunlake*: Could I go back to scales of fees? In 1948 you were consulted and you negotiated with the Ministry under duress and with inadequate time and you did your best; there were some points on which there was disagreement but the Minister promulgated his decision notwithstanding.—Yes.

3281. In 1949, because the Penman Committee had not reported you refused to co-operate and negotiate with the Minister and he promulgated a scale of fees notwithstanding. It does not very much matter what you do, does it?—No, Sir. The Penman Report was published, I think, in August, 1949; it is

before you and you can judge how far it does or does not support the timings we originally worked out.

Discussions for a new scale of fees based on Penman were started. On the 14th February, 1950, we had discussions at the Department. The political situation just at that time caused us to ask whether there was any suggestion that a further alteration in dental remuneration would take place before those current discussions were finished. The Department said not as far as they knew. Unfortunately, the next time we went down there on 1st April, 1950, we were told that there had, as we knew, been a general election at the beginning of March, that there was a new Government in office, that it was reviewing all the Health Service—not only the dental service—and it proposed to put on a 15 per cent. cut. So once again right in the middle of these negotiations we were told that the Minister proposed a 15 per cent. cut, although to be quite fair I think the Department were as embarrassed about it as we were.

3282. *Chairman*: Was that on the gross earnings?—Yes, on the gross earnings. We refused to negotiate on those terms at all with the result that we actually had a 10 per cent. cut imposed on 1st May, of that year.

The next thing came the following year, 1951, when the new Act was introduced which brought in charges for dentures, and in 1952 the charge for treatment was also put on. Naturally, we were not consulted. Those were major political decisions and we were not consulted about those until the Bills were published. We were consulted about the regulations governing them, and as regards the 1952 Bill we did secure several amendments in the House, but that had nothing to do with the end effect that it had on the income of the dental profession.

The result of this was, as is set down in the Ministries' factual memorandum, that by the end of 1952-53, dental remuneration was down to £3,000 gross average, a singlehanded practitioner, of course, being considerably less than that. It did appear to us that there was an immediate *prima facie* case for the restoration of the 10 per cent. cut. Quite clearly, £3,000 gross with a 52 per cent. expense ratio is somewhere about £1,450 net in terms of 1953 money; and

how that was supposed to have represented the Spens terms of £1,600 in 1939 money we could not follow. We felt that an immediate restoration of the cut would not have been out of place. Unfortunately, Sir, and I think this must be said, we were kept waiting five years for that cut to be restored and we have little doubt, and I think I can produce evidence to show, that it was deliberate policy to hold down dental remuneration during this time so that the school dental service administered by the local authorities could be built up. That sounds a somewhat extraordinary statement to make and I would not make it if I could not support it amply from the various debates that took place in Parliament.

In introducing the 1952 Act, which introduced the charges for treatment, the then Minister of Health, Mr. Crookshank, said:

"It is a sad result of the recent system that the school dental service has gone rather into a decline. We hope that these changes may encourage more dentists to enter into contracts with local authorities to work in that service, possibly on a part-time salaried basis."

Later in the debate, Sir, a member of the Opposition, Dr. Summerskill, said:

"I suppose it is very attractive to some people when they are told that if this Bill is introduced the number of patients will decline, as, of course, they will, and the dentists will be forced into the school dental service."

Also later in the debate, Sir, and this perhaps is most important of all, Mr. Macleod, who was then a back bench Member said:

"Of this question of the school dental service, and whether these proposals will be effective, which is in my view the main justification for these proposals, if there is one, I will speak later."

and later in the debate Mr. Macleod said when referring to the effects of the 1951 Act:

"We are told that the salaries of many dentists have dropped by one-third. If dentures accounted for 61 per cent. of their income it follows that the deterrent effect was well over 50 per cent., as I am sure it was. Whatever our views are on charges, and mine are well known to the House,

and whether they will be effective in reinforcing the school dental service or not it is really essential that we should stop this patching."

We submit that those remarks by Mr. Macleod when he was a backbencher indicate quite clearly that he was determined to build up the school dental service and that he realised that the effect of the charges would be a deterrent to patients and would, therefore, lower the income of the dental profession.

A debate took place in July of that same year on the regulations to implement the charges and there was a motion to annul the regulations. By that time Mr. Macleod had become Minister of Health and he had this to say:—

"There has been a substantial fall in the demand for dental treatment during the past month. It is also unquestionably true that a substantial proportion of the estimates submitted have been for those who can claim exemption. It follows, therefore, that the policy of Her Majesty's Government, that where we have not enough resources and enough dentists those most in need shall not go without, is being implemented.

That figure has to be taken also together with the increase in the number of dentists in the school dental service which on the full time basis has gone up in the last six months from 716 to 793."

Finally, a year later, in a debate on Supply, Mr. Macleod still Minister of Health, said:—

"Here I justify what I said a year ago that what we needed was a switch in resources and that there were social and medical reasons for charges in the health scheme."

He then goes on to relate the figures of the school dental service and to say that they had now gone back from 1,000 in 1948 to 1,000 in May, 1953, they had gone back to where they started, and he finished by saying:—

"I tell hon. Members opposite that if they remove the charges on the dental scheme before there is an adequate number of dentists they will destroy all the progress that has been made towards securing that priority for the children."

That was 1953 during which year the average dental income was reduced to £3,000 gross, clearly far below Spens. The Minister of Health was justifying charges because they kept the dental income down and drove men into the school dental service, and we had to apply to that Minister for the restoration of the 10 per cent. cut. Obviously, if he was going to put charges on to keep dental income down, we had not very much hope of getting the 10 per cent. cut back and yet, clearly, I submit that the reduction to £3,000 gross made out a clear case for its immediate restoration.

The history of the restoration is much in line with that. We had applied to the Minister in 1953 and he rejected our application on the grounds set out in the factual memorandum that he did not know what the expense ratio was and he did not know how much private practice was being done. Those were the grounds that were given to us but I do suggest that purely on the figure alone of £3,000 gross, whatever the expense ratio was, and there is no reason to think it had gone down, we were entitled to something more substantial in the way of a reason for rejecting our claim. However, once again, we had to co-operate with the Ministry.

We did co-operate and with the Inland Revenue we went into an inquiry and we sent to the Minister the results of the inquiry in July, 1954, and it was eight months later before we got the Ministry's offer which constituted the 1955 agreement.

That was the history of those five years and I submit that the whole time the dental profession was not being treated on an equity basis, that there were very convenient political reasons not based on Spens or anything else, why that 10 per cent. cut was not restored.

3283. *Sir Hugh Watson*: On page 53 of the factual memorandum there is this statement:—

"The 10 per cent. reduction was intended as an emergency measure pending a review and possible revision of the scale of fees in the light of the Working Party's findings and after discussion with representatives of the profession."

In the light of what you have told us, do you wish to comment on that version of it?—I think the comment is contained in the next sentence where

even in the Ministry factual memorandum they do say, "In May, 1951, however, charges for dentures were introduced." That surely is the answer. We had no opportunity of negotiating anything during that time because there were throughout continual changes going on and on and on. When the final 1952 Bill was through and there was this clear case on the face of it for an immediate restoration, in the same way that the Minister of that day would possibly argue that in 1948 there was a clear case for him doing something, we submit there was a clear case on the figures which he must have had for him to say immediately: "I will give you the 10 per cent. back and negotiate a scale of fees based on Penman." Instead of which, for two years things dragged on. It was July before the final figures he had asked for were submitted to him and the following March before we got this offer. And that was the condition under which the profession had to accept the 1955 agreement. We had five years of this sort of thing behind us and it was the first time we had been offered an increase in remuneration since the Health Service had started. It is not really too much to say that no matter what conditions had been attached to it we were bound to accept it for our members.

3284. You were in fact accepting a restoration of a reduction?—Yes, and tied up with it was the fact that a ceiling was to be put on our earnings for the same amount of work in future. Those were the negotiations that took two years.

3285 *Mr. Gunlake*: Could I ask a question about the effect on the individual dentist of the three cuts in 1949 and 1950? For instance, item (d) in paragraph 74 of your document; there was a 20 per cent. cut in gross fees, which means something like a 40 per cent. cut in net taxable remuneration, does it not? Are you taxed under the P.A.Y.E. procedure?—No, Sir.

3286. So that if a cut of that kind takes place, during the first twelve months after the cut has taken place you are still paying on the previous year's income at a higher level, are you?—Yes. I would like to add one thing. I have said, and said quite definitely, and I hope shown to the satisfaction of the Commission, that it was deliberate policy, as was stated, of the Government to hold down dental remuneration to build

up the school dental service. Now, Sir, nothing I have said could possibly be construed as suggesting that the British Dental Association in any way deplored the building up of the school dental service. Obviously that was not so at all, but we do say that that is the wrong way to do it. You do not build up one particular service by depressing the remuneration of people in another service. The normal way is to raise the salary you are offering in the school dental service but that, of course, was beyond the Minister's power. We were not averse at all to the school dental service being built up but we were averse to the methods employed in doing it.

3287. *Sir Hugh Watson*: You mentioned a ceiling; what ceiling are you referring to now?—That was the ceiling that was part of the 1955 agreement. I think it is stated in paragraph 89 of our memorandum.

3288. You mean where it says: "The aim should be to produce net incomes comparable . . ."—Yes. In other words, that the condition of the restoration of the 10 per cent. cut was that a new scale of fees should be worked out, not based on Spens, not based on Penman, not based on anything like that but based on the 1949 scale which was being restored. In fact in toto the 10 per cent. put it back to the 1949 level but the Ministry and ourselves had agreed that there were various adjustments that wanted making in the scale, particularly in the fees that were offered for the treatment of children which had been disgracefully low during the time of the 1949 scale. Therefore, the effect of that agreement meant that anything that was put on one fee had to be taken off another fee in order to keep the dentist under the ceiling. And that was one reason why those negotiations took two years.

3289. *Chairman*: When you say "under the ceiling" you mean these were comparable to what would have been earned in the period had the 10 per cent. not been in force?—Yes, for the same volume of work.

3290. *Sir Hugh Watson*: That does not necessarily impose a ceiling and, in fact, it did not.—It imposes a ceiling unless the dentist is going to work still harder.

3291. I thought you would say that! This is another large subject on which

we had better not embark at this moment, the question of hours of work and so on. In fact, the figures which have been earned by dentists since then are very much in excess of the £3,000 in 1953 to which you referred?—Yes.

3292. *Chairman*: In fact, if you say ceiling you might just as well have said floor, might you not? It did not say not to exceed?—No, Sir, it did not say not to exceed, but I would not describe it as floor because it is awfully easy to get underneath it!

3293. But the aim was to produce net incomes comparable to those which would have been earned had the 10 per cent. cut not then been in force—comparable, not more and not less?—Mr. Thomas handled those negotiations and I am sure he can elucidate that, whether it was a floor or a ceiling.

3294. I do not mind; elucidate by all means, if you like, but I thought you would probably agree that the aim was to produce comparable net incomes.—It meant it was a redistribution of the scale, the point being that if sixpence was to go on one operation that was done a certain number of times then sixpence had to come off another operation that was done an equal number of times.

3295. Or vice versa?—Or the other way round, yes. It took a tremendous amount of research into the exact number of operations that had been carried out and exactly what they cost, and then to estimate how many were going to be done of that particular standard in the next year and adjust the fees accordingly. But we had to ensure that for the same volume of work no more money was earned above the ceiling.

3296. I was going to ask one of your colleagues this; we did have some suggestion made on an earlier occasion that Mr. Balding had not been a very good fighter for the Association. I take it that to most of you, as it would seem to me, that was not exactly right. Would you care to express a view on that?—*Mr. Swiss*: Yes, Sir, I think I would. I think that particular statement deserves as much attention as many other statements made on the same occasion. Those of us who have the pleasure and honour of working with Mr. Balding know that he is not prepared to give an inch when he knows that he is right. He is also prepared to concede that there may be a

soon as it was suggested, I do not think that the suggestion that the scale of fees was thereby falsified or proved wrong is quite correct. Is it not rather like suggesting that for the rest of the war all the time rates and piece rates and everything in industry should have been fixed on the amount of work that was done immediately after Dunkirk where you had everyone going at it 24 hours a day? It might have been said: "All right, people are earning far too much, we will cut their piece rates, and so on, and those will apply for the rest of the war". That was an exceptional time and so was this an exceptional time. The scale of fees, the rates that were fixed, we suggest had not in fact been falsified by showing they were wrong under normal conditions. But as long as a dentist was working 16 or 18 hours a day, obviously, there would be this terrific bulge. As I say, we would have preferred not to have had the bulge.

3307. *Sir Hugh Watson*: Did your Association suggest to the Minister any other way of running this service than the way in which it was proposed, on an item of service basis?—Our suggestion was, I think, as I have just said, that there should be this gradual introduction with certain priorities for certain classes of persons, age groups, and so on.

3308. Did you ever suggest to the Minister that apart from that it was unwise and not sufficiently far-seeing on his part to go all out and introduce a 100 per cent. dental service from the beginning?—Yes.

3309. You did? How did you suggest it should be done apart from what you have just told us?—*Mr. Swiss*: We made no other suggestion apart from this one of the priority classes, no. Our suggestion was that the introduction of the Service should be confined, first of all, to the priority classes—young children, expectant mothers—and then for the Government to extend this Service and make it available to other age groups after the profession had dealt with the back-log of work for the priority classes.

3310. *Professor Jewkes*: There was never at any time any suggestion that the general method of remuneration should differ from the one that we have now, that is, your payment per operation? No one suggested paying dentists a capitation fee, or anything of that kind?—*Mr. Balding*: No, Sir. I think

it would be quite impossible to pay dentists a capitation fee as long as there is a shortage of dentists.

3311. *Chairman*: What about a whole-time or part-time salaried service, for instance?—That also would be almost impossible as long as dentists were working in their own surgeries. Naturally, dentists, being individualists, like to run their own surgeries in their own way. Unless you are going to put the whole lot into clinics of some description it is difficult to see how you could supervise a salaried service run all over the country in individual surgeries. How are you going to make sure that in fact the dentist is in his surgery at all?

3312. Of course, there will always be some dentists who are salaried and who must be at the same time on more or less a similar footing to their colleagues in their own profession elsewhere, and to their colleagues in other professions in their own sphere of life.—Yes. There are certain types of dental practice that I would almost say could only be done under a salaried service, but the general dental service is not one of them because the practitioners in the general dental service like to work in their own surgeries and I do not think you would ever get them into clinics or health centres or anything else.

3313. There have been suggestions, have there not—I believe it was in the McNair Committee—that perhaps another method ought to be sought?—We are always looking for another method of remuneration. There are any number of disadvantages that one could pick in the present method of remuneration but there are advantages in every method and there are advantages in every method. We have had a committee investigating this in actual fact for most of last year and having gone into it thoroughly they have come to the conclusion that for the time being, until they find something with less disadvantages than the present method, the present method is the proper one.

3314. And this method by its nature would always mean that as efficiency and productivity improve there will always have to be reductions in the amount allowed for particular items if you are to arrive at a uniform total at the end of the year. There will have to be continuing negotiations and discussions on individual things.—I think so, from time

to time, yes. As I agreed this morning the Penman times may be out of date now, I just do not know.

3315. Whenever that happens it will be catching up with efficiency, with improvements that have already taken place in efficiency. It will always cause a certain amount of resentment amongst some members of the profession if they find they are getting less for a particular item of service than they have had before.—If the scale of fees is based primarily on the time factor then if they are taking less time on an average on a particular item, then the fee for that item has to be reduced. But the method of increased efficiency has got to be a method, shall I say, that is in general use, not just one that has only been introduced a short time ago, or one of these high speed instruments with a quarter of a million revolutions a minute that are not yet in public use. If the profession accepts a time basis it has to stick to a time basis.

3316. *Professor Jewkes*: And the Association would not have any objection, say, to another Penman Report forthwith?—I would say that the Association has nothing to hide. It is not trying to put in any false claims at all; and if Penman is thought to be out of date then it is time we had another Penman—as long as we can get down for the first time to negotiating a proper scale of fees on a proper basis without some sort of duress hanging about in the background.

3317. *Sir Hugh Watson*: I started this, I am not suggesting Penman is out of date, but you agreed with me it could be.—It is ten years since Penman reported.

3318. *Chairman*: It would be disappointing if there had not been progress in ten years.—Quite. I am bound to point out that the other angle might be that Penman was taken during the rush hour, 1948, and it is just conceivable that time could not be spent on certain operations then as much as it should be. It might work both ways. If there is any dublety about it, then let us have another Penman.

3319. *Sir Hugh Watson*: Could I ask you a question? There are certain operations which are performed by dentists which have to be referred to the Dental Estimates Board. On another occasion very violent criticism was made of that Board. Could you tell the Com-

mission what your opinion is of the way the Dental Estimates Board works with the profession?—*Mr. Swiss*: I think to speak on that?—*Mr. Swiss*: I think in the first place it must be realised that the dental profession tends to be a profession of individualists. The figures show that 60 per cent. of our profession work single handed. That figure was greater years ago, and when the Health Service came in the practitioners tended to find that their individuality was not always appreciated by the Board. They had to submit—where they had never done before—their clinical opinions to somebody else. Dentistry is not an exact science. There is room for quite honest differences of opinion on clinical matters, and therefore, recognising that there had to be a body controlling the moneys expended on dental treatment, one of the things that we always asked for and the thing that we got was a Dental Estimates Board that was operated by and controlled by members of our own profession. But there was this natural human instinct that an individual was having his estimates queried by someone else, and he tended to resent that. But I am quite sure in my own mind that as time is going on the Board are becoming more understanding; the members of the profession are realising the Board's duties. Another great advantage that was given to us was the system of appealing against the Board's decision where that appeal was heard by two of your colleagues, and above all that the assessment arrived at by those colleagues was hindering both upon yourself and upon the Estimates Board. There will always be individuals who will resent any disagreement with their own ideas, and the Board in the early days had to learn by experience. But I am quite confident in saying that these things are beginning to smooth themselves out. With regard to the other point you raised, Sir Hugh, about the other items for which we have to get the Board's approval, we have, following the recommendations of the McNair Committee, had a discussion—a tripartite discussion—with the Ministry with the members of the Board present. Indeed we set about it by having a meeting with the Board first so that we would perhaps get some measure of agreement with the Board before we went to the Ministry, and that proved most helpful. The only thing is that it does seem to be taking rather a long time. The Ministry had

3330. *Chairman*: But without increasing the demand to the point of full employment?—*Exactly*.—*Mr. Balding*: You appreciate, Sir, how the fees were negotiated in those days? It was not a statutory benefit, dental benefit under the old National Health Insurance. It was an additional benefit covered only by the surplus funds of approved societies. Naturally, I suppose, there was a certain amount of competition between approved societies to give these additional benefits, and they liked to make the money they had go as far as possible and cover as many members as possible. That is only quite natural, and so consequently this setting up a scale of fees with the approved society was done with the fact in mind that—there was only a very limited amount of money available from the societies. That was the situation economically.

3331. At any rate the result of Spens was to propose a considerable increase?—*Yes*.

3332. But it was not in any case to increase the social and economic status of dentists beyond that of certain other professions, but to bring it to within the same sort of broad band—is that right?—*I think so*. It was to put it in its right place which they felt, for the reasons given in paragraph 15, it was not.

3333. And it would appear in the years immediately after the commencement of the service—for reasons of the bulge—that in fact for a time at least the actual earnings went beyond what had been contemplated, possibly because the hours were long, possibly because the timings and method produced more than had been intended. Is that right?—*Yes*. I think it is fair to say that Spens naturally did not in his report mention or anticipate the bulge that took place. He was referring to normal times when the health service had settled down. It is perfectly true that in those early days of course earnings went beyond what Spens said, but that was only as a result of the tremendous efforts made by the profession to cope with the bulge.

3334. *Sir Hugh Watson*: Have you any figures for the incomes of dentists in 1948-49? There are none in the Ministry's Factual Memorandum for that period.—*Mr. Balding*: I think, Sir, the only figures we have were contained in the claim we put to the Ministry, and

that starts in 1949—in April, 1949. We have not got, I think, any figures for the original nine months.

3335. I see. What I was getting at, as you will appreciate, was the Commission would like to know precisely to what figure the incomes of dentists had risen which forced the Government to take action on the 1st December—or to tell you on the 1st December that they were going to take that action. You remember? The Commission have no idea what in fact the incomes of dentists were.—*Mr. Swiss*: You see, the position was influenced by the fact that in 1948 and 1949 it was not as though the whole numbers of the dental profession came into the Health Service on the appointed day. It was rather a sort of dribble in, the numbers increasing as the months went by. Statistics would not be very reliable on that matter, because you had men going in ready to cope with the demand on the appointed day and the others coming in months afterwards.

3336. What sort of proportion went in on the appointed day?—*I would like to give you accurate figures, Sir, which I do not know*.—*Mr. Thomas*: The only figure I can give is the approximate figure for London. The approximate figure for London was out of a potential of 1,200 practitioners. On the appointed day 480, I think it was, went in. They are the approximate figures for London, but I have no others.—*Mr. Swiss*: I can give the approximate figures for Middlesex, with a potential of 450/500, as being round about 100.

3337. If the Government had no better information than that about the number of dentists going into the health service, it was very difficult for them to forecast what the state of matters was going to be. You have criticised them severely because they estimated £7 million, whereas the cost of the first nine months was £18 million. If they did not know the number who were going to join the National Health Service—if in fact the numbers which Mr. Thomas and Mr. Swiss have given were typical, then the Government were in a hopeless position.—*Mr. Balding*: I am not saying I would have liked to forecast how many dentists were going in or how much it was going to cost.

3338. You are pretty savage about it; you say they blandly informed you that they would have to reduce the fees.—*Yes*. We felt they were not making

any allowance for the actual facts as they turned out. There was this tremendous demand for dentistry and, within a few months, the Ministry had to say that this thing was quite hopeless, that something quite desperate had to be done about it. We felt there was no suggestion on the part of the Government that these fees were not properly earned. There was no suggestion that they were earned by bad work or anything like that, and we immediately offered to help—in fact I think the Penman Report says that preliminary discussions went on in January of 1949; although the committee was not appointed until February there had been preliminary discussions in January. In other words we said to the Government that if there was any abuse we were prepared to investigate immediately with them; and they simply said they could not wait for that and that they had to act at once. We felt that in those circumstances they were being unreasonable in not accepting our offer to investigate any abuses that were going on. Otherwise we felt that the thing would straighten itself out unless there was definite evidence of bad work being done—of which they could not produce any. We also suggested that they should investigate some of these alleged high earnings. Subsequently they did investigate them. There were some very high figures in connection with one or two practices which the Ministry investigated and found that they were perfectly satisfied that those figures were—shall I say—legitimate figures. In other words they were practices employing perhaps up to a dozen assistants. But all the cheques were made out in the one name and it appeared that these particular individuals were earning quite fantastic sums, whereas those figures, when they were investigated, represented the earnings of anything up to a dozen men. That was the sort of thing the Government should have investigated straight away. They said no, the thing was becoming a public scandal—I think were the words they used—and they must act at once.

3339. *Chairman*: We shall know after our enquiry with which you have been helping what dentists really are earning now. There is not otherwise any good information as to what they are earning is there?—Now?

3340. Now.—Not until you get . . .

3341. . . the results of that questionnaire. That will give some informa-

tion.—*Professor Allen*: Could I say a word? There is now available the result of the Inland Revenue enquiry which covers the year 1955-56, and that is much more recent information than anything else we have had before. Previous information related to 1952-53. In fact 1955-56 is almost a complete year following the restoration of the 10 per cent. cut and I have, overnight, analysed the figures that have become available to you and to me; a little later on if you wish I can give you my analysis of the results very briefly. This is only up to 1955-56.

3342. We have figures of the gross payments made to dentists for general dental services for all the years from 1951-52 up to 1957-58. 1955-56 showed a big increase over 1952-53 and 1957-58 is about as much of an increase again as that. That may or may not have a bearing. Are your figures somewhat on the lines of those on page 614 in your memorandum?—Yes, they also include not only net income but expenses and expense ratios. The point is of course that the earlier information is for gross payments; there are no figures of expenses or net incomes. I would contend and can illustrate that net incomes are very variable, peculiarly sensitive to the factors at work, and that changes in gross earnings are most misleading when considering net incomes. The figures for 1955-56 do throw light on that aspect as well as on gross payments.

3343. *Sir Hugh Watson*: I do not know if Professor Allen knows the Ministry have now said these figures are inaccurate?—I have seen the corrections which are very small, and the figures that I have got are subject to two small amendments—one the amendments the Inland Revenue are making, and the other the particular way different groups are put together, the weighting which inevitably arises in a sample, but I am quite satisfied that the amendments that will ultimately arise change the picture very little indeed.

3344. *Chairman*: Are these figures based on a larger sample than the figures given on page 614?—Yes, the sample now consists of 1,266 dentists whose accounts ended in a particular quarter—between the 31st December, 1955, and 5th April, 1956.

3345. I think there were only about 700 in the earlier sample.—There were a further 800 dentists who were not used

there is a double reason for setting on one side or considering separately the figures for the under 35s and the 65s and over, but they do amount to about a third of the total. Another third are in the main age category, 35-54—20 years in the middle, and the final third are in the ten year group 55 to 64. So that you get a very odd age structure, a third of them being at each end, a third in the main 20 years of the working life, and another third in the last ten years up to the normal age of retirement of 65. If you look at the figures I have been giving you in the two groups—the 20 years from 35 to 54 and the ten years from 55 to 64—you get a completely different picture of earnings. In the 35 to 54 group the average net income is just over £2,400. In the 55 to 64 group it is just over £1,300. That is a very big difference and I think that is a point that must be taken into account in analysing the figures, and in particular in comparing them with the figure given in paragraph 101 of £1,778, which is shown there to be the figure used as a target for single-handed practitioners, without assistants, in setting up the 1948 scales. This figure was obtained by taking the Spens £1,600 figure and adding a betterment of only 20 per cent. and then taking off the 8 per cent. superannuation. To the extent that that £1,778 figure is a measuring rod the conclusion is, on the basis of the 1955-56 figures, that the dentists in the age group 55-64 were far below it, and the dentists in the age group 35-54 were quite a good deal above it. And that brings me to what were the hours worked? We do not know until you have the result of your enquiry. It seems to me that this is a thing in which the overall averages are peculiarly difficult to work with to the extent it means that the net income of a single-handed dentist is £1,669.

3353. I think you said, Professor Allen, taking the two separate thirds—the 35-54 and the 55-64—that the expense ratio is not very different?—For the 35 to 54 it is 48½ and for the 55 to 64 it is 51 per cent.—earnings being lower the expense ratio is higher.

3354. And this particular comparison with 1952-3 shows that the increase in net earnings is fairly general but is sharpest of all, certainly as a percentage, in the oldest age group?—It is £775

for the oldest age group which is not so much.

3355. Yes, it was about £500 before, was it?—I think it is fairly uniform, but the general impression I have is that the increase is perhaps larger in the middle age groups, which may be connected with hours. In 1952-3 hours were known to be lower because of the charges; they are now known to be higher but there is no measure.

3356. But it is an increase of about a third compared with three years before?—In the average, yes.

3357. And during that time the only change in actual remuneration made was the cancellation of the 10 per cent. reduction in gross fees imposed in May, 1950?—Which would, other things being equal, with a 50 per cent. expense ratio, increase net income by 20 per cent.

Chairman: Yes, unless the expenses had correspondingly gone up.

3358. *Professor Jewkes:* These figures presumably include earnings in respect of private patients?—Yes, they are Inland Revenue gross earnings, Inland Revenue expenses, and therefore a net income figure which is the difference between the two.

3359. So that they are not in any case comparable with the figures that we have in the Ministry of Health Factual Memorandum on page 55 which are simply the gross earnings under the general dental services?—Yes, but I think they are consistent with those figures.

3360. The movements seem to be very close indeed, do they not?—Yes. Additional earnings, as far as I can estimate them from these two sets of figures, are quite small.

3361. It is consistent with the figure of 8 per cent. which is often quoted, is it?—Yes.

3362. *Chairman:* Do we know, Professor Allen, whether all the returns of the dentists in these samples are of those working full-time?—I do not know.

3363. There was for instance in the McNair Report a reference to dentistry being particularly suitable for women, many of whom worked part-time after marriage.—We do have some information but I have not been able to analyse it because all these figures are given in categories of gross professional income.

Taking the England and Wales figures there were 807 single-handed dentists without assistants altogether, 20 of them returned a gross income of under £500 which would indicate, since it was an account for a full year, either part-time working, illness, or some other circumstance of that kind. I can give it to you by age too. Of those twenty, three of them were 55 to 64 and seventeen were 65 and over.

3364. *Chairman*: These figures, Mr. Balding, indicate that there is a somewhat constant graph of earnings of dentists by age group. It indicates there has been a pretty substantial increase during those three years in the net earnings of dentists, just as I think it is clear that there was a pretty substantial fall in the net earnings of dentists between the boom year before adjustments had been made and 1952-53, which was rather near the bottom judged by the gross figures. Is that correct?—*Mr. Balding*: Yes, Sir. The two points are, of course, one, the hours of work, and the other the restoration of the 10 per cent. cut which should increase the net income by 20 per cent.

3365. If expenses had not gone up at all?—If expenses had not gone up as well.—*Professor Allen*: I think, Sir, it would be useful to underline the influence of the restoration of the 10 per cent. cut. The 1952-53 Inquiry for single-handed practitioners only, showed that their net income would have been £1,600 if the cut had not been there and if expenses had remained the same. And that figure is almost exactly the same as the average for single-handed practitioners in 1955-56, the 10 per cent. having been restored.

3366. Yes.—So that the difference between 1952-53 and 1955-56 for single-handed dentists—both Inland Revenue inquiries—it can be argued would be almost entirely a matter of the restoration of the cut of 10 per cent. However, there are other factors at work. The dentists meanwhile have aged more and the age distribution will be different and the hours worked will be different, so that further analysis will be necessary. But the first impression one gets is that for single-handed dentists the earnings in 1955-56 were almost exactly the same as they were in 1952-53 if there had not been a 10 per cent. cut.

3367. *Sir Hugh Watson*: But, of course, the Inland Revenue figures do not tell anything about hours of work?—No.

3368. *Professor Jewkes*: So far all these statistics have been related to single-handed dentists.—The others are in the Inland Revenue returns, but would need a good deal of arithmetical work to combine them or show them up.

3369. *Chairman*: I think we will stick to the single-handed dentists for this purpose because we have not got the comparable figures at an earlier date and you have a much smaller sample.—You get much smaller numbers in the sample when you get beyond the majority of the dentists who are single-handed without assistants. That was the point of my initial remark—to keep some kind of comparability.

3370. *Chairman*: I was going to ask Mr. Balding about the numbers on the whole. Would dentists tend to stop being single-handed later on, take partners or assistants later on in life? He would not be likely to have an assistant before the age of 35 or not so likely as he would later on—is that right?—*Mr. Balding*: I do not think there is any particular pattern. Dentists either are individual and feel they want to be on their own probably all their life or, if they are the sort of person who feels that he can combine with somebody and run quite happily in double harness, then he will take an assistant at possibly quite an early age; and after a few years they will become partners. Or you will get two youngish individuals joining up as partners, joining their practices together; but I do not think there is any pattern. It is so much a matter of the individual and whether he wants to be on his own or whether he feels that he can run in double harness with somebody else.

3371. *Professor Jewkes*: The point I was trying to get at when I mentioned this matter of single-handed practitioners was that the figure that has now been given to us for the existing single-handed practitioner was £1,669—I think, Professor Allen?—*Professor Allen*: Yes.

3372. In the claim the Association made to the Minister in 1956, the figure for 1955-56 for all practitioners is £2,123. Now, we have a chance of going into detail about this later, but it does suggest that there are some very high earnings

weight for the increased skill of the ageing practitioner, a scheme which we have not at the moment. It is not an easy matter to do it. It has fallen to my lot to try to devise something and, although one feels that one is nearing some solution, there are still holes that can be picked in it.

3387. *Chairman*: That brings us to an important point, Mr. Balding. Is there any way of ensuring that the dentist who really is above the average in skill within the National Health Service will receive rather more than the one who is below the average in skill? There are presumably considerable differences in ability, and in a time of full employment that becomes particularly important, does it not? For instance, as Mr. Thomas is perhaps suggesting, can the weighting of different types of work be used to influence that?—*Mr. Balding*: Yes, I think it could be, Sir and, as I did mention briefly yesterday, in the original scale of fees there was in fact a skill factor put on to certain items in the scale, which were not therefore based purely on time. I think that is a possibility that could be explored, the question of weighting certain operations. But the difficulty we were up against in the early days when we tried to do that was that there was this insistence that something had to come off somewhere else.

3388. Yes, this is of course something which we would not attempt to cover in our report, the actual weighting. That would have to be something that would be worked out between the profession and the Ministry, and it would be on the basis of more for more skill and less for less skill. You would not expect it both ways?—No, Sir, but you are now suggesting, or I think the underlying suggestion is some method of grading the profession. Is that what you have in mind?

3389. I was really asking you whether there ought to be a method, and I was taking up Mr. Thomas's point, which ensured by some means that the more skilled dentist, which includes in his view the older and more experienced dentist very often, should be able to earn rather more?—I think it is fair to say, Sir, we have not yet found the method by which that can be done, but we are constantly looking for the solution, and I would say discussing it with the Ministry in various ways. It is easy enough to

put up suggestions that would appeal to us as a profession, but they do not always appeal to the people who have to pay the bill for the suggestions we put up. We did of course put up a suggestion quite recently to the Minister on the question of the possible retirement of quite a number of dentists this year who are entitled to draw a pension, when the Health Service has been in operation ten years. We did suggest to the Minister that as an immediate sort of interim measure there should be a percentage increase added in the same way that the ten per cent. was deducted from everybody. We suggested that a fifteen per cent. increase should be put on automatically to the fees of men over a certain age to induce them to remain in practice instead of retiring at the end of this year or the middle of this year. That was just I would say a suggestion we put forward because we feel that the matter may be urgent. We realise that even after this Commission has reported there will be possibly a year, possibly two years, of negotiation on the scale of fees, and this problem may come up very seriously if a large number—it is estimated at something between 1,000 and 2,000—retire this year. It may upset the whole pattern of the Health Service even as far as it is now as regards full employment for the rest of the profession, so we did put that suggestion up to the Minister. We have not had an official reply to that.—*Mr. Swiss*: We also had in mind as being an interim measure until we reached the pattern to which you referred just now, the younger practitioner earning more and being able to provide for his own old age. Our suggestion about the elderly practitioner had nothing to do with merit at all; it was just purely on age, and it was purely a suggestion both for the point Mr. Balding referred to, namely, to encourage the anticipated number who will be retiring, to carry on, and also as a measure to help the older practitioner who has not benefited by being in the Health Service as a young man.

3390. *Sir Hugh Watson*: The two points that were mentioned earlier; he cannot sell the goodwill of his practice, and he cannot put up his fees—for what there may be in these two points.—Yes.—*Mr. Balding*: On the question of selling the goodwill of his practice, you will appreciate that a large number of

men who are reaching retiring age now have paid a considerable sum of money as young men for those practices. They bought the goodwill before the Health Service started many years before the war, and they naturally expected when they started that they would be able to sell it. But they will not be able to. So they feel particularly badly about this particular matter, that they have put this capital into the practice and they will never get it out.

3391. *Chairman*: It is quite true, is it not, Mr. Balding, that the average dentist who paid his goodwill before the war has in fact since the National Health Service earned a great deal more than he earned before the war on the average?—Yes, he has shall I say had a freer public, more patients coming to him undoubtedly. He has worked considerably harder and he is entitled to earn more, but that still does not alter the fact that the capital he put in he will never get out.

3392. *Professor Jewkes*: But is it not true, Mr. Balding, that in a way the decline in the value of this capital is due to the fact that there has been a big increase in the demand for dentists? So much so that any dentist can set up his plate and probably find plenty of work. In a sense you have had a quid pro quo for the fall in the capital value, since of course it has been easier to increase your week-to-week and month-to-month income.—Yes, but the men who are going to retire within the near future, although their incomes have gone up because they have had more work they still have not been able to do the amount of work, because of their age, that the younger men are able to do, the younger men who have come into the Health Service and have in fact started in practice since the Health Service started. They have never had the benefit of their earnings on that pattern when it comes to their pension, you see. Their pension has been related to their final years, whereas a young man coming in on this pattern of earnings will have a pension which is related to his whole service.

3393. *Chairman*: It is perfectly clear that those people who have served the whole of their life in the National Health Service will come off better on pension than those who only came in towards the

end, but you are not proposing that the Health Service should cover the back years of dentists before the Health Service was established, are you?—No, Sir. I do not see how we can ask for that.

3394. *Mr. Gunlake*: What happened to the dentists who retired on age grounds very soon after the Health Service came into operation? Was the value of their goodwill destroyed completely as soon as the Health Service came in, or was there a gradual erosion?—I think it was destroyed very rapidly.

3395. And they had no pension at all under the Health Service scheme?—No.

3396. *Mr. Watson*: Is there no provision for him to receive a payment based on his three years previous earnings?—Not unless he has been in for ten years.

3397. After he has served ten years in the Health Service, what would he a fair figure as an average to show what a dentist will get on pension?—*Mr. Barry*: If he had been earning £4,000 a year gross for ten years he would then get a pension of £300 a year, a lump sum of £300 a year and a widow's pension of £100 a year. That is if he was over 60.

3398. If he died before ten years service what would his widow get?—One year's net income, which in that case would be round about a £2,000 lump sum.

3399. So that even if goodwill has been lost there is a shield under the Act to make some recompense in the form of pension and grants?—The only point is that these superannuation benefits are obtained by contributions made by the dentist, because the net income level fixed in 1948 had deducted from it, as the Spens Committee recommended, the employers' superannuation contribution. So it is a form of compulsory saving to which the State does not contribute at all.

3400. *Chairman*: Coming back to this question of reward for merit which has some relation to this, it has been put to us by another body whom we have not yet heard in public that the need and effective demand for dentures tends to increase and to divert dentists from conservation work, and that the conservation work is really one of the more skilled

jobs that ought to be more highly remunerative for dentists. Is that broadly true?—*Mr. Swiss*: Figures show that the trend is indeed in the opposite direction, that on the one hand with the appreciation by the public of the care of the teeth the figures for the number of conservative treatments are steadily rising and the number of treatments for the provision of artificial dentures is slowly declining. We consider that that is a pattern that will continue and as more care and more education is given there will be even greater emphasis on conservative treatment than on the other side of dentistry. And the profession themselves are doing everything to encourage that.—*Mr. Balding*: I have just been looking at some figures from the report of the Ministry of Health, 31st December, 1956, which I think is the latest one that is available. In the general dental services the courses of treatment for which payment was claimed in 1953 were 6½ million; the courses of treatment requiring prior approval of the Board were 1½ million. Now, Sir, this is only to give you a very rough figure because all dentures require prior approval; so that the figure then in 1953 was 6½ million to 1½ million. In 1956 the total number of courses for which payment was claimed had risen to 8½ million of which 1·7 million were for dentures. So that the proportion which required approval, which largely means dentures, had gone down in proportion to the total number of courses. That is a very rough answer taken from those Ministry figures, but I think it is a fair statement as regards the trend of dentistry in the Health Service.—*Mr. Swiss*: I think Mr. Balding is being more than fair because in the number that required prior approval, although the denture item is the largest item, there are all the questions of orthodontic treatment, and there are all the questions of more elaborate conservative treatment. So that, although those proportions are there and show the trend, they might be even more when actual figures are found, probably when the Dental Estimates Board give their evidence.

3401. Would you say, Mr. Balding, that there are some dentists who would not be quite good enough to do some conservative work but would be able to do the dentures and the extractions? Is there a degree of skill and merit there,

or not?—*Mr. Thomas*: Trying to answer that, Sir Harry, I would say that there would be a very very small number now. That might have been true at the beginning of the Health Service, but now there will be a very small number, and I would say after this year the number would be almost nil.—*Mr. Hindle*: What I would like to suggest—you might have some other ideas—is that there is no less skill required from the dentist who provides dentures than from the dentist who is doing conservative work. The amount of skill required for the provision of dentures is certainly comparatively as high as that of conservative work.

3402. *Sir Hugh Watson*: Can you tell us, Mr. Balding, or perhaps Mr. Buchanan, why the remuneration of dentists in Scotland is so much lower than in England?—*Mr. Balding*: If you look at the table in the Ministry factual memorandum on page 55 you will find that in the first figure, 1949-50, the gross income in Scotland was higher than it was in England. In 1950-51 it was higher. It was only in 1951-52 and in 1952-53, when the awful impact of the charges had really sunk into the Scottish nation, that the fees became lower in Scotland than in England, but I have no explanation to offer.

3403. *Mr. McIntosh*: May it not be true that practically all the Scottish dentists came straight into the National Health Service, whereas there was a delay factor in England?—Yes, I think that might be true. In answer to a previous enquiry you were making about the number of dentists who came in, I have had a chance to look up the Ministry of Health report for 31st March, 1949, which relates to the period at the beginning of the Health Service. The report says that on 10th July, 1948, there were 5,386 dentists out of an estimated total of 10,000 who were in the Health Service; that is within a week of the start of the service, according to these figures, half the profession was actually in. By the end of July there were 6,000; at the end of August there were 7,000; at the end of October 8,000; and by the end of January, 1949, there were 9,000; so that it went up almost 1,000 a month. Then it goes on to say that the popularity of the new service soon became evident. It had been expected that the demand for dental treatment under the service would run at the rate of 4 million cases

per year, but in fact the demand in the period under review was at the rate of 7 million cases per year, and there was a peak demand during that time running at the rate of 8½ million cases per year; that I think, Sir, is the bulge. There is no question about that, the demand from the public was double what the Ministry had anticipated.

3404. *Sir Hugh Watson*: It has been suggested to us on another occasion that the question of dilution was troubling your profession, the question of dilution or the employment of ancillaries. Is that causing you anxiety?—The Dentists Acts have gone through; they are now law, providing for an experiment in the training of ancillary workers. We can but await the outcome of that experiment.

3405. It was put to us on another occasion that probably the biggest fear of the profession is that insecurity is being created by the fact of dilution. You do not share that fear?—No Sir, it is not the biggest fear of the profession at all. Insecurity yes, but not arising from that; arising from the matters we were discussing yesterday.

3406. Not from this specific point?—Not from that. The profession, Sir, has almost at the moment forgotten that the Dentists Act has gone through. The experiment has not started yet, and I could not possibly say that dentists are kept awake at night by the thought of the experiment.

3407. There was another matter raised on that occasion which puzzled the Commission a little. It was alleged, as indeed we know, that the profession had a very unfair Press and a very unsatisfactory Press. Did the profession ever take any steps to counter the articles and so on that appeared by correcting in the Press the false impression formed in the mind of the public?—We are getting on to a very tricky subject.

3408. Do not pursue it if you do not want to; I do not mind.—I would only say the answer is yes we did put out various facts from a different angle of course, presenting true facts as we saw them, but they did not always receive the publicity that various other facts—which were not altogether always facts—received. But it was beyond our control.

3409. You have no information, have you Mr. Balding, about the volume of private practice of dentists?—Mr.

Marshall: From our inquiry in 1952-53 it was then shown that approximately 8 per cent. of the total volume of dentists' work was attributable to private practice. What the percentage is now of course we cannot tell, but it may be revealed by your inquiries.

3410. *Professor Jewkes*: It will apparently be revealed by the recent expense ratio inquiry, will it not?—*Professor Allen*: Yes, I would think so in part.

3411. Since the results of the expense ratio inquiry include private practice, and since we know what the dentists were paid from the public purse, it should be the difference between the two.—Mr. *Thomas*: I think that is true, Professor Jewkes, but speaking as a practitioner who had a large private practice prior to the inception of the Health Service, private practice has virtually ceased to exist.

3412. I had been thinking of this in connection with the problem of the older dentist, but the point I think you made, or Mr. Buchanan made, was that the older dentists do less work but in some ways their work is of a higher quality. I would have thought this might have provided one outlet for the older dentist in that, providing higher quality service, people might be more attracted towards him for the purpose of private practice. Does nothing of that kind occur?—Of course the attitude of the public is—"I pay so much a year and I do not see why you should not treat me under the Health Service", and it is very very difficult to say otherwise than yes to a patient who has been your patient for the past forty years.

3413. *Chairman*: Is it not sometimes difficult for the patient who has been your patient for the past forty years to come to you and say—"I would like to be treated under the National Health Service"?—I should like to think it was difficult, but I have not found in practice that it is so.

3414. But when you treat a private patient, even the few who are left, there is an element of time payment as well as item of service payment as a rule, is there?—Yes.

3415. That is one way in which the slower, older and more experienced person can cover himself in comparison with

the younger, more rapid one, if there is a time element?—It could be so, Sir.

3416. In general, for the general dental services under the National Health Service you do not want a time element introduced, Mr. Balding, do you? You prefer the item of service method?—*Mr. Balding*: Yes, but that is based on time, Sir.

3417. But it is an item of service that does not vary according to whether the man who is thirty can do twice as much as the man who is sixty. But you are not suggesting any variation; you want an item of service payment throughout?—I think so.

3418. *Sir Hugh Watson*: I was going to ask about the remuneration of the hospital dentist. Up to now that has been a matter of direct consultation with the Ministry?—Are you referring to the general practitioner dentist in the hospital?

3419. No, I am referring to the people you deal with in your paragraph 111. They are hospital dental consultants—I misdescribed them. It is all under the general heading of Part VIII. There are other grades; they are not all consultants of course. These are the people I am referring to. You suggest they should come under the Whitley Council?—Yes, Sir, that is at their wish. They are at the moment taking part in the consultations with the Joint Committee of Specialists, and I do not think yet they have actually been taken into the Whitley Council but they are trying to get into the Whitley Council. It is not our suggestion; it is what they are actually trying to do. They are actually trying to do that, and it is a matter of discussion between the management side and the consultants as to whether they are going into the Whitley Council or not.

3420. *Chairman*: But that is separate from the ordinary dentist. The general dental surgeon who deals with an ordinary medical or surgical case, including I think you mentioned also the accident case—he is just in the ordinary way of a dental practitioner who visits the hospital for that purpose?—That is in Section II, paragraph 114. He of course has nothing whatsoever to do with the Joint Consultants body or with the Whitley Council. We do his negotiations for him; the Whitley Council or the Joint Consultants body do the

first category. This second particular category is one that we feel has been treated perhaps more harshly than any category of dental surgeon under the Health Service inasmuch as he is still offered this rate of £150 per annum for weekly sessions. He has just received an increase of £7 10s. under the interim award but, as we point out in this memorandum, Sir, he is offered £150 per annum for every session of 3½ hours, which works out at something under £1 an hour. At the same time of course this is a part-time post, and his overhead expenses are just running on at his own practice. His staff is there, everything is there, and he just goes away for three hours to a hospital and receives this £150 a year.

3421. You say it is under £1 an hour. That is on the basis of a 46 week year, because I notice that some other calculations were made on the basis of having a six weeks' holiday?—*Mr. Thomas*: For a time, Mr. Chairman, I was engaged in that service, and it was a question of a session every week.

3422. Fifty-two weeks a year?—*Mr. Cocker*: A holiday period is allowed; forty-six weeks is the time.

3423. It is in fact a six weeks' holiday allowance?—I do not think they all take advantage of it.

3425. Why do they go in for this service if it is so unsatisfactory?—*Mr. Balding*: I think it is fair to say a good percentage of them were in it before the Health Service started. In the old days before the State took over the hospitals of course they took appointment as an honorary, and those appointments were very sought after. It was considered a great honour to get an appointment to a hospital as an honorary dental surgeon. Then in due course after you had been there a good many years higher appointments became vacant; they again were honorary, and it led up possibly to your becoming a consultant on hospital work, jaw work for example, and that is how the consultant service in the old days was built up. Under the National Health Service there is no connection whatsoever between the general dental surgeon and the surgical specialist, and you can remain a general dental surgeon after forty years on that hospital staff. When the Health Service started, Sir, that was the position, and there were men all over the country who took great pride in the

fact that they did a session or two sessions a week at their local hospital, but the position now is quite changed. When, however, they have done it for perhaps twenty years they just do not want to give it up; they keep it on. But that does not alter the fact, Sir, that although they still do it because they have always wanted to do it and they do not like to sever it, that they are getting grossly under-paid.

3425. But there has been an increase in the amount done, has there not, or has this fallen off?—I do not know, Sir. Quite frankly I cannot answer that. You mean have there been more people appointed?

3426. I thought there was more general dental work going on in ordinary hospitals than there used to be.—*Mr. Cocker*: The general dental surgeons who are in hospital today number less than they did. The man who is established there sticks, he has a loyalty to the place. When you seek to replace him by a younger man when there is a vacancy the young men do not want it; they just cannot afford it. That is the answer you get. I have spoken to many young men time and time again when we have had vacancies to fill, and that has generally been the reply I have got. There are a few who come in of course. At that time they have got to get on with making their career for their later lives if they are ever going to make them.

3427. Is this the part of the service that could use the older dentist who may find difficulty in earning as much as that in practice, compared with the younger dentist who will find it easy to earn a great deal more?—*Mr. Balding*: I think that is a possibility, Sir, yes. I do not think we have ever looked at it in that light, but if this was made sufficiently attractive. . . .

3428. But I gather it is considerably more attractive, from the figures Professor Allen gave us, than being a dentist in general practice over the age of 55?—Yes, Sir, except that the point here is that the overhead expenses and so on in a man's practice are still going on, and he is just getting this sessional rate. It becomes a question of whether he thinks he could earn more in his own surgery or whether the sessional rate is such that he will earn more if he goes to the hospital to do the work.

3429. Is there a bit of a parallel with the school dental service? Is that also on a sessional rate?—Some of it, Sir, but that is rather a different story I think. I think it would be unfortunate if the school dental service had to recruit its members entirely from elderly practitioners. There are certain things in treating children that some elderly men will like, especially if they have done it all their lives, but for a man who has not been very keen shall we say to treat children in his own practice it would be disastrous if he were suddenly introduced into the school dental service at perhaps the age of 55-60 just to give him a living. I think the effect on the children would be rather disastrous. A man either likes treating children or he does not. Sir, and I do not think you can get away from that.

3430. You say the number of full-time general dental surgeons is very small?—Yes.

3431. How small?—About seven men.

3432. *Sir Hugh Watson*: Mr. Balding, in order to determine the future level of remuneration you suggest compulsory arbitration. I do not know if you know that various bodies who have given evidence to this Commission have suggested various other methods. As far as I can remember no-one else has suggested compulsory arbitration. You know what the set-up of the Coleraine Committee is?—Yes, I have an idea.

3433. The Coleraine Committee is purely advisory, its functions are purely advisory. Would you think that such a body would not be appropriate for this purpose?—I would not like, Sir, to give a specific answer on that. I think I am right in saying the British Medical Association published their ideas on this particular term of your remit in the last British Medical Journal.

3434. I have not seen that.—I have here a memorandum that was sent to you, Sir, last week. We saw it on Monday, so that I would not like to comment on it from our angle as to whether that particular thing would suit us. When we were arriving at this paragraph here we did consider the Coleraine Committee's functions, but we felt that in our particular case arbitration was probably

a better solution to it. I would say that if we have any second thoughts after having gone into the B.M.A. suggestions and if we feel that they would be applicable to the dental profession and that they would be better, we will undoubtedly, when we come back as I imagine we shall have to later Sir, let you know about it. But at the moment, Sir, we would be reasonably happy with a system of arbitration such as this, a special arbitration tribunal. We are not suggesting that this should be dealt with by the Industrial Tribunal; it has obviously got to be somebody who knows something about not only Health Service matters but in particular about dentistry.

3435. *Chairman*: Suppose we arrived at a recommendation as to what the proper levels of remuneration should be within the profession and then there is a system devised to produce that but which in fact does not produce it but produces something quite different. Such a thing can easily happen on these very complicated questions of timings, items of service and changes in the kind of machinery available—it can happen either way. Are you wanting arbitration to be used to come to the figure that has been intended, or are you wanting arbitration on changes, for instance in the value of the pound or on remuneration of other people, to decide what the appropriate level should then become, or both?—I think it might be either, Sir. The thought behind this is the fundamental thought that I think is in the dental mind, the question of insecurity; that up till now we have been entirely at the mercy of the Minister who can change our remuneration overnight. We have no appeal to any independent party. That is really why we feel we must have an independent person, acceptable both to the Minister and to the profession, to whom an appeal can be made. It is this business of the Minister being able, literally overnight, to alter things, and not only to alter things drastically, but really in some cases to undermine or take away a tremendous amount of work that a man has put in. I am thinking that in the early days of the Health Service, in order to meet this demand, dentists did expand their premises; they put in extra surgeries, put in extra workshops, laid out a tremendous amount of capital. And overnight that was just cut away;

they had to cut down their staffs and they had all this useless capital expenditure on their hands. That is the sort of thing that has made the profession so dissatisfied, and the sooner the final word does not rest with the Minister of Health who is subject to political and parliamentary pressure and everything else, the better we shall be pleased.

3436. But there really are two quite different questions, are there not? There is the establishment of a proper level of remuneration, whatever that may be, and there is the devising of a method to achieve that level through items of service in most cases. And that method may go wrong, in either direction. Are you wanting arbitration for both?—I think so, Sir. I think that the arbitration machinery would be used whenever there was some quite impossible dead stone-wall dispute between ourselves and the Department or the Minister. It might very well be a question of whether the particular scale of fees is or is not in fact producing this result or that result, or whether it is due to other circumstances such as the bulge or the cuts. We want somebody to settle our differences with the Minister, somebody to whom we can appeal, somebody we know is impartial and is going to give us a fair judgment on it. But at the moment if ever a dispute like this arises, as it has in fact arisen, the Minister says—"This is producing this result; I am going to do so-and-so", and there is nothing we can do about it.

3437. One of the most important things to do is to have as many facts as possible available so that at least you are arguing about the same thing. —True.

3438. Is there anything more that can be done to make sure the facts are up to date? We have just got the results of this 1955-56 inquiry in the middle of 1958, and I would not think anything could be very much quicker than that on that subject. Is there any other way of being quite sure what the facts are? —No, Sir, as far as we are concerned we have never been afraid to face the facts, but what has happened, as I did explain yesterday, is that in the past while we have agreed to help to find those facts something has happened in between right in the middle of those negotiations. The Minister has said—"I am going to act now, I cannot wait to get those facts". That is where the

arbitration machine might be used quite well, to stop these sudden cuts in the middle of a fact-finding investigation, such as with the Penman Report; and when the Penman Report is produced and the Minister has the facts, without waiting for the negotiations, he cuts again. We have never been afraid of facts; we have always offered to co-operate with the Minister in finding facts, but we have twice had these cuts produced in the middle of negotiations, Sir, and that is why we feel this arbitration machine is the thing. As regards the Inland Revenue inquiry, I think we have now come to an agreement with them to produce some inquiry every year based on 25 per cent. of the sample in the four-yearly inquiry.

3439. Inevitably that is bound to be rather late in producing any actual figures. You cannot have them within a year of the time the expenses were incurred.—No, they will always be behind, of course.

3440. *Mr. Watson*: I wonder if the Association has thought out this question of arbitration. Assume the value of money rises 10 per cent. in the next five years. The Minister then comes to the Association and says that means a 10 per cent. reduction in these items of service; would the Association then proceed to arbitration?—I should think it might be the Minister who might have to go to arbitration.

3441. That is what I am saying; it takes two to go to arbitration. Has the Association thought it out that there could also be not a difference between you but a difference in ideas as to what the items of service should be and the cost?—If I am following you as to what the items of service would be, it would hardly be appropriate if the Minister said, for instance, "I propose to take dentures out of the Health Service"—that is a political decision, it is not a matter for arbitration. It is a question of Government policy if he is going to do that. Even though we had arbitration machinery we should, of course, not use it if the Minister decided as a matter of politics to put the charges up or cut the charges down; that is a political issue which we are still subject to, and the political issue is an uncertainty which we as a profession will always have to face in this Health Service. But on financial matters—if the cost of living goes down very markedly

—then I would agree with you, Sir, we cannot have it both ways; we should have to be prepared for the Minister to go to arbitration. We cannot ask just to have arbitration machinery when it suits us.

3442. *Chairman*: Are you suggesting that the decision of the arbitrator should be binding?—I think so, Sir.

3443. It is a compulsory arbitration, with compulsory binding results over a very broad and quite undefined front, is it?—Yes, Sir. This is a general picture I have put before you, the general picture that is in our minds of what we want, to avoid the happenings of the past. But we have not laid down here exactly the terms of remit and just how wide the scope of the arbitration machinery should be. That I think would clearly be a matter for discussion if it ever got to the stage of an arbitration machine being set up; this is the broad picture of the arbitration machine we see. After examining the British Medical Association's suggestions, if we have any second thoughts on it, Sir, then, as I assume that we shall possibly have to have another meeting with you when your questionnaire results and so on are out, if we have any comments we wish to make on that we could do so.

3444. I think that is certain.—And we have promised to let you have some comments on the first recommendations of Spens.

3445. You have excluded from the scope of this arbitration suggestion for instance whether the Government should increase charges for dentures or reduce charges for dentures. You include within the scope of arbitration the effects on you, is that right?—I do not see what Government would ever put its political plans to arbitration; I only wish they would sometimes.

3446. I am only trying to get at what you are suggesting.—We are not suggesting that these political matters can go to arbitration.

3447. This particular paragraph about arbitration does not, naturally, go into very great detail. I would still like to see how some of it is going to work. You are suggesting really that in questions of remuneration the profession should be bound by the decision of a third party on what it should do in general and in detail?—Yes, we do

say here in paragraph 130—" . . . arbitration machinery to which the profession may resort as of right in the event of a breakdown in negotiations on terms and conditions of service . . ." That is a broad picture of what we are suggesting. Of course at the moment it is possible for us to go to arbitration if the Minister will agree to it, but we do not think the machinery is altogether suitable even then, Sir, because it does not come before an arbitration court that has some special knowledge of dental problems, Health Service problems and things like that. But we do feel that we should have the right to arbitration if there is a breakdown, and that it should not be dependent upon the other side saying—"Yes, all right, we will agree to your going to arbitration."

3448. Arbitration would have to be on some sort of definition of the point being arbitrated, would it not? That would presumably have to be an agreed one?—Yes. You mean the point of dispute would have to be agreed?

3449. Yes.—Yes, I think so.

3450. At the present time any dentist in the service can withdraw from the service at any time he wishes, can he?—Under certain circumstances, Sir, yes. He cannot just walk out and leave his patients in the air. He has to make arrangements for the completion of treatment, and he of course has to give three months' notice.

3451. *Sir Hugh Watson*: You know, Mr. Balding, there is no other form of government employment where people are paid salaries or remuneration at the level here in question where matters are settled by arbitration?—I did not.

3452. I am told that is so.—I see, yes.

3453. You are going to consider this matter and consider the B.M.A. proposal which is something very like the Coleraine Committee?—As far as we could see from a quick glance it was.

3454. *Chairman*: I do not think we have got anything more we want to say at the moment. We have got a general impression of your point of view, Mr. Balding, and we understand in particular the conditions affecting the dental profession relating to the falling off on the whole in latter years. I gather that broadly your feeling is that your remuneration for normal effort in times of full

employment ought to be comparable with that in other professions of similar standing, and should take account of the recruitment and of the need to keep the profession manned. Are those the main points?—Yes, Sir, and the problem peculiar to the actual physical practice of dentistry, the hours that a dentist can physically work.—*Mr. Swiss*: There is one request I would make to you, Sir. When comparing the remuneration of the dental profession *vis-à-vis* the medical profession, would you bear in mind the tremendous amount of work that is done by dental practitioners in the smooth running of the dental services under the National Health Service. In every locality in the country there is a Local Dental Committee, there is a local Executive Council, there is the Dental Services Committee, on all of which there is dental representation. We are delighted to have it, but those dentists in attending to those functions that enable the service to work smoothly are away from their practices, losing remunerative time. The medicals also are members of these various committees, but their method of remuneration being different from ours, they are not losing any of their remuneration by attending all these meetings and doing this work; whereas the dental practitioner when he is out of his surgery is ceasing to earn but his expenses are continuing. It is a point, Sir, that we would ask you to bear in mind. The same comparison is also applicable to the pharmacists. Their method of remuneration is such that they do not entirely lose their remunerative time in doing this additional work. It is a peculiarity of the dental profession.

3455. But that will be thrown up by these figures of average earnings overall?—Yes, Sir, bearing in mind the hours of work.

3456. *Mr. Watson*: Is there no provision made for loss of remuneration for men attending Dental Services Committees?—The dental man gets the same as the lay member and other members, merely a token payment for loss of remunerative time.—(*Mr. Balding*): I think it is £1 up to four hours.—(*Mr. Swiss*): £2 I understand, Sir, for the whole day.

3457. *Chairman*: That is a common practice throughout industry, commerce and all walks of life, is it not, that people

who are engaged in public service on behalf of their colleagues through trade associations or whatever it may be usually do it largely at their own expense?—Yes, Sir, but their pay goes on. If they are paid on a salary basis their salary is continuing; they are not losing actual remunerative time. We make all our money with our hands and if our hands are not engaged in work, if we are away from our surgery, our income is immediately affected.

3458. Are you asking us, Mr. Swiss, to try and make some arrangement whereby those who spend all their time working should get less and those who do not spend all their time working should get a little more to compensate?—I am only asking you to bear this in mind when you are making comparisons, which I believe are always odious.—(Mr. Balding): It is a point, Sir, that we have found the greatest difficulty in getting people to realise, but when they do realise it they do appreciate it, that in this work on the Health Service machinery side we are the only profession whose income ceases entirely while we are doing that work. That is all, Sir. We are not asking for any special treatment or special payment for it or anything, but it is just a fact, that of the three professions largely engaged, the

medical, pharmaceutical and ourselves, we have a direct loss of income which we can never make up. We cannot go back to our surgeries after an afternoon's meeting and work there from six to ten in the evening.

3459. And that is the result of the item of service method of remuneration?—Yes.

3460. By which you stand?—Yes, it is one of the disadvantages, it is true, but it is there, and if we do not bring it to your attention nobody else will.

3461. Mr. Watson: You could come on to a salaried service and be treated the same as the others.—(Mr. Swiss): That would deal with that particular difficulty but would probably raise others.—(Mr. Balding): It is dealt with, Sir, in paragraph 44 of our memorandum.

3462. Chairman: Have you anything more you wish to mention at this stage, Mr. Balding, or any of your colleagues?—I do not think so, Sir, thank you.

Chairman: All right, thank you very much. We will, as you say, probably be seeing you again later, and if you have any more thoughts arising out of anything that has been said and if you wish to send in any memorandum no doubt you will do so.

(The witnesses withdrew.)



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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

14—15

Fourteenth Day, Thursday, 17th April, 1958

Fifteenth Day, Friday, 18th April, 1958

WITNESSES

H.M. Treasury

Ministry of Health

Department of Health for Scotland



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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

FOURTEENTH AND FIFTEENTH DAYS

Thursday, 17th April, 1958

Friday, 18th April, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MR. A. D. BONHAM-CARTER, T.D.

MR. I. D. MCINTOSH, M.A.

MR. J. H. GUNLAKH, C.B.E., F.I.A.,

SIR DAVID HUGHES PARRY, Q.C.*

F.S.S.

SIR HUGH WATSON, D.K.S.

PROFESSOR JOHN JEWKES, C.B.E.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

EXPLANATORY NOTE BY THE ROYAL COMMISSION

Following the publication of the Factual Memorandum by the Ministry of Health and the Department of Health for Scotland (Written Evidence Volume I, H.M.S.O. 1957) the Royal Commission, at an early stage in their labours, gave consideration to the broad questions affecting medical and dental remuneration on which they wished to have the views of the Government.

A list of 22 questions was drawn up by the Commission and the memorandum reproduced in the following pages contains the answers to these questions, prepared on behalf of the Government by H.M. Treasury, the Ministry of Health and the Department of Health for Scotland.

After dealing with the Commission's questions the memorandum concludes with some observations on the statistical evidence presented to the Commission by the British Medical Association.¹

This volume also contains two earlier memoranda—"Civil Service Salaries" and "Machinery for Reviewing Pay in the Higher Civil Service"—submitted to the Royal Commission by the Treasury.

* Fifteenth day only.

¹ Royal Commission on Doctors' and Dentists' Remuneration. Minutes of Evidence. Days 5-6. H.M.S.O. 1958...

Remuneration of General Practitioners and Hospital Medical Staff. Case submitted to the Ministers by the Profession. (B.M.J. Supplement, 28th July, 1956.) "Changes in the Distribution of Higher Incomes" by Professor R. G. D. Allen. ("Economica", May, 1957.)

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JOINT MEMORANDUM SUBMITTED BY H.M. TREASURY, THE MINISTRY OF HEALTH AND THE DEPARTMENT OF HEALTH FOR SCOTLAND**(1) The Government's view of the nature and extent of the obligations to the medical and dental professions undertaken by the Government of 1945-50 in accepting the Spens Reports.**

1. The statements made on behalf of the Government at the time of their acceptance of the reports are reproduced verbatim in Appendix I. The terms of the acceptance are important. The announcements were that the recommendations were accepted in substance in the case of the General Medical Practitioner Report and in principle in the case of the Consultant and Specialist and the Dental Reports. In all three cases, the Government intimated that they were ready to discuss with the professions the translation of the acceptance in substance or in principle into substantive systems of remuneration.

2. It was, of course, the Government's intention, that in these discussions due account would be had to the fact that the recommendations on remuneration were expressed in terms of 1939 values; to the observation made by each Committee that the necessary adjustment to conditions at the time of their report "should have direct regard not only to estimates of the change in the value of money but to the increases which have in fact taken place since 1939 in incomes in other professions"; and to the view expressed by each that only if corresponding changes were made in the remuneration of doctors and dentists would recruitment and status of their professions be maintained against other professions.

3. The view taken by the Government was that, when remuneration in the new service was settled, the purpose of the Spens Reports would be fulfilled. Evidence of this view is contained in the Departmental record of a meeting on the 22nd December, 1949, when representatives of the General Medical Services Committee sought an assurance from officials of the Ministry of Health—

"that the Central Pool will be continuously adjusted so as to maintain in the future—whatever the changes necessitated by the heavy burden of work falling on general practitioners and whatever the increase in the number of doctors—the levels of remuneration recommended in the Spens Report and which were accepted by the Government."

The representatives were informed that the Government's acceptance of the Report was a settlement at a particular time and the British Medical Association could not properly claim that whatever changes occurred in the volume of work to be done or in the economic state of the country or other factors the profession would for an indefinite time receive remuneration based on the Spens Report. There was no intention at present of lowering the remuneration of general practitioners. If the number of general practitioners changed there would be a *prima facie* case for review but no assurance could be given.

4. Some months later the Minister of Health informed representatives of the British Medical Association at a meeting on the 3rd April, 1950, that the Spens Report could not be regarded as a continuous basis for remuneration (cf. supplement to British Medical Journal, 22nd April, 1950, page 164).

5. When those statements were made the actual remuneration required for general practitioners in the service to give effect to the Spens recommendations was still in dispute but the dispute was resolved by the Danckwerts Award. The remuneration of consultants and other hospital medical staff in the new service was settled in July, 1949, as from the inception of the service on 5th July, 1948, when the Joint Consultants Committee accepted the Terms and Conditions of Service of Hospital Medical Staff in which the rates of pay were embodied and advised hospital medical staff to sign substantive contracts. While the British Dental Association expressed dissatisfaction with certain points in the Terms and Conditions of Service of Hospital Dental Staff, especially the remuneration of general dental practitioner appointments, later in 1949 they advised members who were offered contracts as consultants or senior hospital dental officers to accept them. As in the case of medical staff,

the remuneration for these appointments, which was the same as that provided for consultants in medicine and senior hospital medical officers, had effect from the 5th July, 1948.

6. Statements made on behalf of the Government on the status of the Reports since the original settlements of remuneration, are set out in Appendix II. It has always been the Government's view that, after settlements related to the Spens' recommendations had been reached, any subsequent revision of the remuneration of doctors and dentists in the National Health Service should be determined in the light of all relevant circumstances. The Spens Reports remain on record but the Government consider that, while they are still a relevant circumstance, their relevance has necessarily diminished with the years and they are no longer the sole factor to be taken into account.

7. The Government consider that the primary consideration to be taken into account in determining the remuneration of doctors and dentists in the National Health Service in contemporary circumstances is the level of remuneration now received by members of comparable professions.

(2) The significance of the Danckwerts Award—whether it relates only to the years for which Mr. Justice Danckwerts decided the size of the Central Pool; or whether the Award has any bearing on what should be the remuneration of general medical practitioners now and in the future.

8. The terms of reference for the adjudicator were:—

"To determine the size of the Central Pool, after taking account of remuneration from all other sources received by general practitioners, in order to give effect to the recommendations of the Spens Committee, having regard to the change in the value of money which has taken place since 1939, to the increases which have taken place in the income in other professions and to all other relevant factors."

9. The adjudicator determined the size of the Central Pool for the year ending the 31st March, 1951. Everything else in his award—the full text of which is given in paragraph 125 of the Health Departments' Factual Memorandum—is explanation added in order that the determination might be applied to other years.

10. The adjudicator explained *inter alia* that he had applied a betterment factor of 100 per cent to the figure agreed between the Ministers and the General Medical Services Committee for 1939 and that, in his view, the corresponding factor in 1948 would be 85 per cent.

11. On the 25th March, 1952, the then Minister of Health (Mr. Crookshank) informed the House of Commons of the award in the following terms:—

"... as the House is aware the late Government agreed to refer the doctors' claim to an adjudicator on the understanding that his award would be binding on both parties, subject to agreement being reached on an improved method of distributing doctors' incomes. The present Government continued these arrangements ..."

Mr. Crookshank went on to say—

"As I understand it, the late Government accepted the principles of the Spens Report and what the adjudicator has now to decide is the sum of money which he considers necessary to give retrospective effect to the Report, as accepted by the Labour Government."

12. On 13th May, 1952, the then Minister of Health (Mr. Macleod) explained at an interview with the Chairman and Secretary of the General Medical Services Committee that the Government could not accept the contention advanced by the Committee that the Award implied the use of a betterment factor higher than 100 per cent in the calculation of the Central Pool for 1951–52. The Departmental records shew that the Minister explained that acceptance of the Committee's interpretation of the Award would mean automatically insulating the medical profession, alone among professions, from the ill effect of any rise in the cost of living and neither

the then Government nor any Government could contemplate such a course. Nor did he think that the Spens Committee's recommendations necessarily implied such a conclusion.

13. The General Medical Services Committee published the following in a leaflet which was circulated in 1952 to general practitioners in the National Health Service:—

"The award also lays down a betterment increase of 85 per cent for the year 1948-49 and 100 per cent for the year 1950-51. In the course of discussions with the Ministry it became clear, however, that not only was the Government unwilling, as they put it, to 'insulate' the profession for all time against fluctuations in the cost of living, but they also held the view that a varying betterment factor to be applied each year was not part of, nor could be inferred from, the terms of the Danckwerts Award. On learning the Government's view on this aspect of the award, the Chairman and Secretary of the Committee sought an interview with the new Minister of Health, the Rt. Hon. Iain Macleod, M.P.

At this interview, the Minister stated that, whilst accepting the Danckwerts Award and emphasising that it was his Government's policy to present the necessary Supplementary Estimate for additional moneys to Parliament, he could not accept the Committee's contention that this involved the principle of a varying betterment factor to be applied to future years.

Subsequently, the following letter was received from the Minister,

"I am writing to confirm what I told you when I saw you, Dr. Stevenson and Mr. Taylor on Tuesday last. The Government have decided that in pursuance of the Danckwerts Award the Central Pool should be calculated on a betterment factor of 85 per cent for 1948-49 and 1949-50 and of 100 per cent for 1950-51 and subsequent years.

I do not, on reflection, think it necessary to make any special public announcement in the House or elsewhere at this stage; the decision will, of course, emerge in any statement presented to Parliament when approval is sought to the supplementary estimate needed to meet the additional expenditure arising from the award."

In reporting the Government's firm decision on the betterment question, the Committee wishes to make it plain to the profession, as it has done to the Minister, that in their view the award is capable of the interpretation that a varying betterment factor should be applied to future years."

14. This correspondence expresses the difference between the views held by the British Medical Association and the Government as to the nature of the Spens Report and the Danckwerts Award. In the view of the Government the Report and the Award were the means of settling the remuneration of general practitioners in the National Health Service at its introduction and for a substantial period thereafter, but they should not be regarded as setting up permanent principles. They consider that as ten years have now elapsed since the Service was inaugurated, the time has come for a new and fundamental review of the proper levels of remuneration for doctors and dentists in the Service; that this review should pay regard primarily to the levels of remuneration now being received by other professions and connected occupations, and also take account of changing conditions both in the National Health Service itself and in society as a whole. While the Spens Report and the Danckwerts Award are a relevant part of the history of the matter, they should not be regarded as determining factors for the future.

(3) The reasons for the Government's decision not to consider on its merits the claim for increased remuneration submitted by the medical profession in 1956.

15. The medical profession were informed of the Government's decision in the following words:

"They (Ministers) do not accept the premises on which the memorandum is based. In their view, the remuneration of the medical profession, like that of others, must be determined from time to time in the light of all relevant circumstances. The Ministers have asked us to say that in present circumstances they would not feel justified in giving consideration to any claim for a general increase in medical remuneration."

It was subsequently made clear that no opinion one way or another had been expressed on the merits of the claim but economic circumstances made it impossible to consider it at that time.

16. At the time when this claim was made the economic situation of the country had for some time been exceptionally difficult. The gold and dollar reserves had fallen to a very low point at the end of 1955, and there were marked symptoms of internal inflation. In the latter part of the financial year 1955-56 the Government announced a number of important measures for dealing with this situation. The Bank rate was increased to 5½ per cent. Measures were taken to restrict investment and borrowing by local authorities. Reductions were made in the investment programmes of nationalised industries, and the budget of 1956 gave no net relief to taxpayers but maintained the increases in taxation which had been imposed in the emergency autumn budget of 1955. It was a primary object of these measures to produce greater stability of prices and of wages, and to this end a special appeal was made to both sides of industry to exercise restraint, and industry was asked to avoid increases in prices and, wherever possible, to make reductions.

17. For these reasons the middle of 1956 was an exceptionally inappropriate time at which to consider a claim for an increase of 24 per cent from a profession which, as a whole, is in the higher range of remuneration. In a number of other cases where a good claim on merits had been established for an increase of remuneration for other people in the higher salaried classes (Minor Judiciary, Members of Parliament, Junior Ministers) the Government decided that increases must be deferred. Even at the beginning of 1957 they felt unable to accord an increase to university staffs with effect from October, 1956, and this increase in fact took effect from 1st August, 1957.

18. The considerations which made it necessary to defer these other claims applied with ever greater force to the doctors' claim because the Government were quite unable to accept the premises on which the claim was based. The cost of conceding the claim in full would have been about £20 million a year in respect of the National Health Service and as members of the medical profession are employed in a number of public services the repercussions on other salary earners of an award to doctors would have been widespread. To have entertained this claim at the time it was made would have been inconsistent with the Government's general economic policy and with their attitude towards other claimants in the higher salaried groups.

(4) Information and views on the adequacy, in terms both of numbers and quality of recruitment :

- (a) *to the medical profession. The Commission understand that this subject has been dealt with by the Willink Committee. It would be helpful if the Government could give the Commission an indication of the contents of that Report and, if possible, their views upon it.*
- (b) *to the dental profession. The Commission would be glad to have information about the extent to which recruitment may have altered since the publication of the McNair Report; and an indication of any action which the Government propose to take to implement the recommendations in that Report.*

The Medical Profession

19. The report of the Willink Committee has been supplied to the Royal Commission. From the Committee's terms of reference it will be seen that they were required to make an estimate of the future number of doctors and medical students required; they were not concerned with the quality of entrants to the profession and did not consider it. The report shows that, on the basis of their estimates of the future needs for doctors in Great Britain to provide the likely expansion in medical employment and to meet losses by death and retirement, the Committee have concluded that, whilst the medical schools in Great Britain have not produced too many doctors up to the present, a reduced output would suffice in future and have suggested that, as soon as practicable, a cut of about one-tenth should be made in the number of students admitted to medical schools. This suggests that present

recruitment is more than adequate in quantity. The Committee thought that the present cut in output would have to be restored after 1975 and that by about 1980 would have to be raised by about 200 above the current level. They suggested, however, that since their forecasts were unavoidably speculative the matter should be reviewed again in about 10 years' time.

20. The Government have drawn the attention of the University Grants Commission to the Committee's conclusions.

21. The Willink Committee record (paragraph 103 of their report) that information obtained from Deans of Medical Schools shows that, of the students who embarked on the medical course proper (i.e. beginning the second M.B. stage of training) in the post war years, less than 6 per cent failed to complete the course and qualify. This, together with the fact that there had been many more applications for places in Medical Schools than vacancies would not lead one to expect that the quality of those selected for the vacancies has been inadequate. The matter is, however, not one in which the Government are able to offer direct evidence or considered opinion and the Commission may wish to consider seeking the views of the medical teaching and examining bodies.

The Dental Profession

22. Before the appointment of the McNair Committee in March, 1955, universities were seriously short of candidates for dental places. Since then, however, there has been a marked increase in the number of candidates and the following table shows the number of dental students (in England and Scotland; there is no dental school in Wales) who started the first year of their professional training in the academic years 1950-51 to 1957-58:—

<i>Academic Year</i>	<i>Number of Students</i>
1950-51	545
1951-52	551
1952-53	519
1953-54	451
1954-55	456
1955-56	558
1956-57	582
1957-58	632

The total capacity of the schools is just under 650 which means in effect that most are now full.

23. The McNair Report recommended that the intake of dental students should be increased as soon as possible to 1,000 each year if the acute shortage of dentists is to be overcome and, in order to achieve this expansion, recommended that universities should at once consider how best they could provide additional places either by making better use of existing accommodation and facilities or by way of new building. Plans for such expansion are at present under discussion between the Health Departments, the University Grants Committee and the Universities, but physical possibilities have to be settled and the problems considered in the light of the total cost. In the meantime, most universities are making such adjustments as are possible within their existing accommodation to enable the maximum number of students to be admitted.

24. At the moment it is understood that candidates of first-class quality are coming forward and competition for dental places is very keen. The McNair Committee concluded that there were two causes of particular significance for a shortage of recruits to the dental profession:

- (a) public ignorance of the importance of dental health; and
- (b) the attitude of dentists towards their conditions of practice.

25. In regard to (a) the main recommendation in the Report was that the Minister and Secretary of State should take the initiative in setting up Committees to co-ordinate publicity concerning dentistry in general and dental health education in particular. The Committee for England and Wales has been set up and has met twice. A corresponding Committee is being established in Scotland.

26. In regard to (b) the Committee concluded that the root of the trouble might lie in the present *method* of remuneration and its consequences and recommended a thorough review of the whole system. The British Dental Association have indicated to the Departments that they do not wish the present method to be altered, and the general question has been left in abeyance pending the report of the Royal Commission. A further recommendation of the McNair Committee was that the Ministers, in consultation with the British Dental Association and the Dental Estimates Boards, should review the list of treatments set out in the National Health Service (General Dental Services) Regulations as requiring prior approval. The British Dental Association have since submitted some suggestions for relaxing the prior approval arrangements. These are under consideration in consultation with the Association and the Dental Estimates Boards.

(5) Any information which may be available to the Government about the alteration in the load of work carried out (i) since 1939, (ii) since 1948, by

- (a) *general medical practitioners ;*
- (b) *general dental practitioners ;*
- (c) *hospital doctors and dentists in the various grades.*

The Commission recognise that there may be a lack of objective data on parts of this question ; but would welcome as much information as possible.

General Medical Practitioners

27. The load of work of general medical practitioners depends partly on the number of patients, partly on the number of consultations per head, and partly on the time per consultation. As regards the first, there has been a steady reduction in the average number of patients per doctor in recent years, as shown in the following table :

TABLE 1
Average size of List

ENGLAND AND WALES

1952	1953	1954	1955	1956	Average annual decrease
2,436	2,324	2,293	2,283	2,272	Per cent 1·7

SCOTLAND

					Per cent
2,078	1,995	1,981	1,975	1,967	1·4

These figures are slightly higher than the average number of actual patients for whom the doctor is responsible, owing to the inflation of doctors' lists.

28. Evidence about the number of consultations and time taken per consultation was submitted to Lord Cohen's Committee on General Practice in the National Health Service (see Section V of their Report published by H.M.S.O. in 1954). More recently the Willink Committee has considered the information available on these matters.

29. The evidence submitted to the Committee on General Practice and published in their Report suggested that patients have, on average, about five consultations a year, three of them at the surgery and two at home. There was no significant change between 1939 and 1948 but a slight increase between 1948 and 1951 to about five and a half. According to this particular piece of evidence, time taken for a consultation was, on average, about ten minutes.

30. The Willink Committee considered what allowances they should make in their estimates of the future number of doctors to meet—

- (a) the forecast increase in the size of the total population ;
- (b) the forecast rise in the proportion of elderly people, who make greater demands on medical services than younger people ;
- (c) changes in the average consultation rate for reasons other than (b), i.e. any tendency for the 'average' patient to make more, or less, calls on medical services.

For (a) and (b) the estimates in the Committee's Report included an annual increase of 75 doctors in general practice (i.e. about 0.4 per cent per annum). But for (c) they said that the evidence was meagre and conflicting with no discernible trend and made no allowance either way.

31. It is relevant here to note that the Committee's estimates for the medical profession as a whole provide for a 13 per cent increase in the number of doctors in Great Britain over the period 1955 to 1971 during which time the population is expected to grow by only about 4½ per cent.

32. The Government's view generally has been that while there may have been a slight increase in the consultation rate in recent years, this increase has been offset by the decrease in the average number of patients and has not been such as to constitute a significant factor.

General Dental Practitioners

33. There are no figures available to indicate the alteration in the load of work carried out by dentists since 1939. There are, however, figures for the period since 1948 and Tables 3 and 4, give for England, Wales and Scotland, details of the total number of full courses of treatment and the total number of emergency cases treated to show the two main categories:—

- (a) treatment for which the prior approval of the Dental Estimates Board is required—this consists mainly of extractions and the provision of dentures ;
- (b) treatment for which no prior approval is required—this consists mainly of conservative treatment.

The tables also show the total number of dentists in the Service in England, Wales and Scotland at the end of each year. The figures in Table 3 show that in England and Wales there has been a further steady rise in the number of dentists providing services and, apart from the periods immediately following the introduction of charges in 1951 and 1952, there has also been a steady increase in the total number of courses of treatment provided and in the number of courses per dentist. (General dental practitioners, unlike general medical practitioners, are paid on a fee-per-item basis and, in consequence, an increased load of work borne by a dentist brings a corresponding increase in remuneration.) Table 4 shows that in Scotland, despite a decline in the number of dentists, the trend in terms of total courses of treatment and number of courses per dentist is similar.

Hospital Doctors and Dentists

34. The points to be considered when assessing any alteration to the load of work of hospital medical and dental staff are:—

- (a) Changes in the volume of work compared with changes in the number of medical staff.
- (b) Changes in methods of treatment.

Changes in the volume of work

35. No comparable statistical information is available for the period between 1939 and 1949.

*The general trend from 1949**The number of in-patients*

Tables 5 and 6 show that between 1949 and 1954 there was an increase of 6.4 per cent in the number of available staffed beds, and that the number of beds has since remained the same. The daily average of occupied beds which rose by 7.6 per cent between 1949 and the end of 1954 has since fallen back to a level of 6.6 per cent above 1949, but the total number of patients treated (as measured by discharges and deaths), has continued to rise, having increased by 27.3 per cent since 1949. The latter figure is perhaps the best measure of the load of in-patient care on hospital medical staff.

The number of out-patients

There has been a continuing rise in the total number of out-patient attendances at consultative clinics since 1949, the percentage increase being 7.3. The number of new out-patients seen at consultative clinics has increased by 12 per cent, and this again is probably the best measure of the load on hospital medical staff. In addition casualty department attendances have increased by 14 per cent.

Changes in hospital medical and dental staffing

Since 1949 there has been an increase of 30 per cent in the number of doctors and dentists of all grades employed in the hospital service, the increase in the number of consultants and senior hospital medical (and dental) officers being 30 per cent and 26 per cent respectively. Over the same period there was a decrease of 25 per cent in the number of senior registrars, but at the same time the number of registrars and others greatly increased so that there was nevertheless a total increase of 32 per cent in staff of below consultant and senior hospital medical (and dental) officer level.

It would appear therefore that since 1949 the increase in the total numbers of hospital staff has more than kept pace with increases in the volume of work; but it must be borne in mind that the volume of work has to be measured not only by increased turnover of in-patients and out-patients but also by the increasing complexity and number of modern diagnostic and therapeutic procedures and their more frequent application to older patients who would formerly have not been considered fit, for instance, for surgical treatment.

The position in selected specialties

36. The changes in the volume of work are not, however, evenly spread between specialties as can be seen from the table below showing, for England and Wales, the increase since 1949 as measured by deaths and discharges in selected specialties, compared with increases in the number of consultant staff.

TABLE 2

Specialty	Discharges and deaths			Consultants		
	1949	1956	Percentage Increase	1949	1956	Percentage Increase
General medicine ...	401,745	498,836	+ 24	642	813	+27
General surgery ...	663,708	806,620	+ 21.5	792	853	+ 8
Gynaecology ...	178,471	272,894	+ 53	370	426	+15
Obstetrics ...	392,925	429,043	+ 9			
Orthopaedics ...	132,984	225,812	+ 70	227	316	+39
Paediatrics ...	91,205	96,297	+ 6	150	200	+33
Radiotherapy ...	21,686	26,042	+ 20	78	115	+47
Thoracic Surgery ...	9,860	22,962	+133	44	85	+93

Position in Scotland

37. Precisely comparable statistics cannot be provided for Scotland and the figures quoted in the tables are therefore for England and Wales, but the trend shown by Scottish figures is broadly similar.

Changes in the type of work required of Hospital Medical Staff

38. There are certain other factors in addition to the measurable changes in the volume of hospital work and numbers of hospital staff which also have to be taken into account in assessing changes in the load of work on hospital medical staff.

(a) *A change in the function of hospitals* has been taking place during this century and especially during the last twenty or thirty years. From being primarily residential institutions to which the sick were admitted for medical and nursing care in the wards, they have become much more consultative centres with facilities for specialist investigations and treatment largely outside the wards. Out-patient consultation has come to take a very large place in hospital practice.

(b) *Changes in the method of treatment*

The development of more powerful modern drugs and of more radical surgical procedures has made possible greater precision and effectiveness of treatment, and because of this it is now possible to give some patients in the wards therapy specifically directed at their disease when formerly they might only have received symptomatic medical treatment and nursing care. The use of these modern therapeutic weapons calls for continual and careful medical control by personal observation of the patient and by laboratory observation of specimens collected from him. The new measures, however, require more concentrated attention, particularly of junior medical staff, both in carrying out the actual procedures and in ensuring that the right steps are being taken.

On the other hand some modern methods have greatly shortened the period of stay in hospital and in some cases simplified the treatment of serious illnesses even to the point of making admission unnecessary.

The use of modern anti-bacterial drugs has probably had a bearing on the length of time that some patients stay in hospital. Illnesses which would normally have involved a long period of stay in hospital can be treated with these drugs, and the proportion of time the acute stage bears to the length of the stay in hospital has been increased.

During the last ten or twenty years it has therefore become increasingly important that complicated technical procedures shall be carried out at precisely the right moment. On the other hand, the development of modern drugs, and of, for example, modern anaesthesia have resulted in the possibility of cure or treatment when previously this was impossible. The consultant's task may now require greater precision and refinement of diagnosis and treatment and the junior staff whom he supervises may have to undertake many more technical procedures in respect of individual patients; and the penalties of omission and commission have become more serious for the patient. But this has to be balanced by the fact that the treatment of the patient is assisted by the use of well developed technical procedures. It is hard to say whether the strain on the hospital medical staff today of using the more complicated procedures which are available, is in general greater than the strain on the medical staff twenty years ago who carried the burden of treating patients without having these procedures available to them. More can be done and what can be done requires more precise assessment, but there are more aids to that assessment and more medical colleagues to share the burden of decision.

Hospital dental staff

Changes in the volume of work

39. Paragraphs 34 and 35 above and the figures in Table 5 relate to the total volume of work of hospital medical and dental staff. The Table 7 provides separate information about changes in the volume of hospital dental work which can be read in conjunction with the changes in the number of hospital dental staff shown in

Table 6. In the absence of comparable figures for staffed and occupied beds for the early years, it is not possible to draw firm conclusions from the large increase over the years in discharges and deaths, but the available figures indicate an increase in the rate of turnover.

Changes in hospital dental staffing

39A. Since 1949 there has been an increase of 37 per cent in the number of all grades employed in the hospital service. The increase in the number of consultants and senior hospital dental officers is 7 per cent and 47 per cent respectively.

Changes in the type of work required of hospital dental staff

40. Before 1948 consultant dental advice and treatment in hospitals was, generally, with a few notable exceptions, confined to dental teaching hospitals and the dental departments of medical teaching hospitals. There is no information available prior to 1948 with which to compare the development of the hospital dental service which has taken place during the last five years following a somewhat slow start. Table 8 which relates to information obtained from hospitals other than Dental teaching hospitals, shows a satisfactory increase both in the total number of sessions devoted each week to consultant and to general dental care. The increase in the number of fully equipped dental surgeries in hospitals is equally satisfactory.

41. Consultant dental advice has increasingly been sought by general dental practitioners in connection with oral conditions. Typical examples which may be quoted include the surgical removal of impacted teeth, the diagnosis and treatment of cysts and tumours of dental origin, and the provision of dental prostheses. The treatment of fractures of the jaws and facial bones, increasingly a common feature of road accidents, has been canalised through maxillo-facial centres.

42. A recent important development still largely in its early stages has been the setting up in a number of regions of a consultant orthodontic service. By this means facilities are afforded to the school dental service as well as general dental service for the diagnosis of irregularities in the positioning of the teeth and jaws, advice as to treatment and, where necessary, the treatment of the more complicated cases.

43. Table 8 indicates the extent to which the general dental care of long-stay patients in, for example, mental, chest or orthopaedic hospitals, has been extended.

44. In connection with these developments it was necessary to make provision for the supply of artificial dentures, special prostheses and splints. To this end central laboratories have been established, usually in conjunction with an existing maxillo-facial laboratory.

45. Mention may be made of post-graduate training at the Institute of Dental Surgery which came into operation in 1948 and which, in conjunction with the Eastman Dental Hospital, has furnished many of the recruits to the hospital dental service. Refresher courses for general dental practitioners under section 48 of the National Health Service Act, 1946, are almost entirely manned by members of the consultant staffs of the dental departments of teaching and general hospitals.

46. In all the foregoing directions there has been a marked change in the nature of the provision of hospital dental care.

TABLE 3
Numbers of dentists and dental treatments—England and Wales

Year	Number of dentists (including assistants) in Service at end of year	Number of Courses of Treatment (1000's)			Number of cases of emergency treatment (1000's)	Total Col. 5 plus Col. 6 (1000's)	Cases per dentist Col. 7 divided by Col. 2
		Which included treatment requiring prior approval ^(c)	Others	Total Number			
1	2	3	4	5	6	7	8
5th July to 31st December, 1948 ...	8,900 ^(f)	744	1,402	2,146	—	—	—
1949 ...	9,500 ^(f)	2,812	3,956	6,768	1,041	7,809	820
1950 ...	9,660 ^(f)	3,324	4,281	7,605	1,981	9,586	995
1951 ...	9,690 ^(f)	2,566	4,667	7,233	2,732	9,965	1,025
1952 ...	9,490	1,647	5,157	6,804	2,196	9,000	950
1953 ...	9,470	1,431	5,241	6,672	1,703	8,375	885
1954 ...	9,600	1,537	5,904	7,441	1,895	9,336	970
1955 ...	9,790	1,592	6,343	7,935	1,989	9,924	1,010
1956 ...	9,920	1,707	6,912	8,619	2,121	10,740	1,080

Notes:—

(ⁱ) These figures included some duplication which was avoided in later returns from Executive Councils.

(²) The majority of these are for the supply of dentures.

TABLE 4
Numbers of dentists and dental treatments—Scotland

Year	Number of dentists (including assistants) in Service at end of year	Number of Courses of Treatment (1000's)			Number of cases of emergency treatment (1000's)	Total Col. 5 plus Col. 6 (1000's)	Cases per dentist Col. 7 divided by Col. 2
		Which included treatment requiring prior approval ^(†)	Others	Total Number			
1	2	3	4	5	6	7	8
5th July to 31st December, 1948 ...	1,180	*	*	*	*	600	509
1949 ...	1,212	*	*	*	*	1,187	979
1950 ...	1,251	393	538	931	268	1,199	959
1951 ...	1,254	319	545	863	350	1,213	967
1952 ...	1,207	189	609	798	296	1,094	907
1953 ...	1,175	158	638	796	262	1,058	900
1954 ...	1,163	180	678	858	280	1,138	978
1955 ...	1,152	193	735	928	306	1,234	1,071
1956 ...	1,142	208	763	971	320	1,291	1,130

* Information not available.

† The majority of these are for the supply of dentures.

TABLE 5
Hospital Statistics: In-Patient and Out-Patient Statistics since 1949 to 1956 (England and Wales)

	1949	1950	1951	1952	1953	1954	1955	1956	Thousands Percentage Increase
Staffed beds	448.0	453.5	461.9	468.3	473.6	476.9	476.4	476.9	6.4
Occupied beds: daily average	397.6	402.6	406.8	416.1	424.1	427.6	426.0	423.8	6.6
Discharges and deaths	2,937.0	3,085.5	3,259.2	3,414.4	3,543.5	3,630.3	3,652.0	3,739.2	27.3
Total out-patient attendances at consultative clinics	26,001	25,249	25,863	27,010	27,152	27,548	27,645	27,897	7.3
New out-patients at consultative clinics	6,148	6,193	6,299	6,606	6,731	6,767	6,787	6,887	12.0
Total casualty department attend- ances	10,108	10,644	10,869	11,513	11,446	11,215	11,561	11,559	14.4

Notes:

- (1) The figures in earlier years are not always strictly comparable with those for later years but the trends can be accepted as representative.
- (2) The figures include dentistry.
- (3) The figures for staffed beds prior to 1953 include all the beds allocated to particular departments and include some unstaffed beds.

TABLE 6
Estimated Numbers of Medical and Dental Staff, by grades, from 1949 to 1956 (England and Wales)

Grade	1949	1950	1951	1952	1953	1954	1955	1956	Percentage Change 1949-1956
Consultants:									
Medical	4,959	5,418	5,649	6,028	6,165	6,269	6,400	6,490	+ 30.9
Dental	232	236	237	246	252	248	250	249	+ 7.3
Senior Hospital Medical Officers	1,860	1,940	2,130	2,200	2,245	2,282	2,318	2,314	+ 24.4
Senior Hospital Dental Officers	159	189	197	221	224	227	229	234	+ 47.2
Senior Registrars:									
Medical	1,390	1,452	1,353	1,081	986	1,033	1,029	1,020	- 26.6
Dental	24	30	33	32	30	36	42	46	+ 91.7
Registrars:									
Medical	1,462	1,674	1,652	1,915	2,061	2,210	2,348	2,438	+ 66.8
Dental	16	29	31	43	41	42	49	50	+ 212.5
Junior Hospital Medical Officers	401	422	492	468	473	491	559	592	+ 47.6
Junior Hospital Dental Officers	1	5	8	1	2	1	1	—	—
Senior House Officers (Junior Registrars):									
Medical	780	926	1,318	1,502	1,656	1,751	1,847	1,932	+ 147.7
Dental	4	17	11	14	19	16	20	16	+ 300.0
House Officers (including Dental)	2,633	2,630	2,783	2,763	2,553	2,611	2,616	2,681	+ 1.8
Total:									
Medical	13,485	14,462	15,377	15,957	16,139	16,647	17,117	17,467	+ 29.5
Dental	436	506	517	557	568	570	591	595	+ 36.5
Medical and Dental	13,921	14,968	15,894	16,514	16,707	17,217	17,708	18,062	+ 29.7

Notes:

- (1) The figures for registrars downwards exclude a few part-time and honorary staff whose number is unknown.
 (2) The figures do not include general practitioners working part-time in the hospital service under paragraphs 10 (a) and 10 (b) of the Terms and Conditions of Service, nor general dental practitioners occupying similar posts.

TABLE 7
Hospital Statistics: In-Patient and Out-Patient Statistics, 1949 to 1956 (England and Wales)

Dental

	1949	1950	1951	1952	1953	1954	1955	1956	Percentage Increase 1949-1956
Staffed beds	126	165	205	236	249	274	261	291	131.0
Occupied beds: daily average ...	—	—	—	—	181.6	211	209	234	—
Discharges and Deaths ...	7,552	10,506	12,137	14,776	16,835	19,747	20,291	23,124	206.2
Total outpatient attendances ...	1,087,640	1,172,605	1,137,486	1,106,909	1,292,536	1,325,230	1,274,000	1,326,725	22.0
New out-patients	330,894	326,625	329,720	319,355	359,527	376,368	340,013	348,563	5.3
Total casualty department attendances	—	—	—	—	—	—	—	—	—

Notes:

- (1) The figures for staffed beds prior to 1953 include all the beds allocated to dentistry and include some unstaffed beds.
 (2) Attendances in casualty departments: separate figures for dentistry are not available.

TABLE 8

Dentistry in Hospitals other than Dental Teaching Hospitals (England and Wales)

	1953	1954	1955	1956
Number of sessions a week:				
Consultant	569	635	723	772
S.H.D.O.	588	679	742	800
Senior Registrar	115	154	152	129
Registrar	88	167	352	381
J.H.D.O.	161	197	252	211
General Practitioner	660	726	852	885
Total sessions of all grades	2,181	2,558	3,073	3,178
Number of fully equipped surgeries	358	381	397	416
*Number of hospitals with no dentist of their own who call, as required, on a dentist holding an appointment at another hospital in the Group	252	509	573	727

* The number of sessions undertaken for these hospitals is unknown but is included in the figures of total sessions shown above.

(6) The Government's views on whether there is any case for considering the establishment of some permanent hospital grade above senior registrar and below consultant in all specialties; or whether on the other hand the Commission should base its salary recommendations for consultants on the assumption that in the three main specialties consultants are responsible not only for work requiring the highest type of skill and responsibility, but all other routine specialist work not within the scope of the training grades.

(14) Distinction awards—whether the value of awards and the percentage of consultants receiving awards are about right in present circumstances; and whether this additional remuneration should continue to be given to individuals on the basis of personal distinction rather than the responsibilities they undertake.

47. Points (6) (hospital staffing structure) and (14) (distinction awards) are considered together here, because (a) levels of remuneration must be determined by reference to work, the nature and responsibilities of which are clearly defined, and (b) the present system of distinction awards is an integral part of the general arrangements for remunerating consultants as a body.

Staffing Structure

48. Before considering the grades of hospital medical staff and the system of remuneration envisaged in the Spens Report on Consultants and Specialists, it is necessary particularly, in relation to point (6), to examine the grade of senior hospital medical officer, not envisaged by the Spens Committee but introduced into the staffing structure in the course of the discussions on remuneration between the profession and the Health Departments in 1948-9. (A parallel grade of junior hospital medical officer was also introduced, but this is not relevant to the present question.)

49. Briefly it may be said that the grade of senior hospital medical officer was inserted in the staffing structure between the grades of consultant and senior registrar because there was general agreement at that time that the staffing of the hospital service required an established specialist (but not consultant) grade with unlimited tenure. The need arose for two main reasons. The first was a purely temporary one—that at the outset of the new service, inheriting a variety of staffing patterns, the proper place in the new staffing structure had to be found for a number of established and experienced specialists who were not trainees but who

had not the training and standing necessary to justify grading them as consultants. The second reason was more permanent in character—that the needs of the hospital service made it essential—at least in some specialities and in some hospitals—that there should be specialists below the consultant grade who should perform work of limited scope, of lower responsibility and requiring less skill than that of the consultant but who should not be holders of merely temporary and short-term appointments like senior registrars.

50. The need for the senior hospital medical officer grade was confirmed and its nature and scope more precisely defined in the discussions between the profession and the Ministry of Health which resulted in the memorandum of October, 1950, attached as Appendix K of the Factual Memorandum of the Health Departments to the Commission. This agreement makes it clear that what was envisaged was the employment in certain specialities of senior specialists assisting consultants (reference was made to "Assistant Anaesthetist", "Assistant Pathologist", "Assistant Radiologist" etc.) for the purpose of carrying out the more routine and less responsible work. In certain specialities, however, no place was seen for assistants of this kind, viz. general medicine, general surgery (including urology and proctology), obstetrics and gynaecology (practised together), cardiology, dermatology, otolaryngology, neurology, neuro-surgery, plastic surgery, thoracic surgery. Table 10 shows the number of senior hospital medical officers in each specialty at 30th September, 1957, and at 30th June (31st December for Scotland) in each of the previous four years.

51. Since 1950, in the course of the discussions on hospital staffing between the profession and the Health Departments, the view has been advanced from more than one quarter that certain of the considerations which led to the agreement of 1950 in relation to some specialities apply more widely, and that there is in the three main specialities also a place for an assistant grade with unlimited tenure. For example, in 1955 the Joint Consultants Committee submitted to the Health Departments (without any commitment on the part of the Committee) a report on hospital medical staffing which stated that the introduction of new and improved techniques has increased the demand for experienced medical staff below consultant level, and which proposed the introduction of an intermediate grade to perform highly responsible work under the final responsibility of the consultant. Posts in the highest range of this grade, falling between the consultant and senior registrar levels, would have been unlimited in tenure. This proposal was, however, not pursued by the profession in subsequent discussions; but more recently, for example, in the *Lancet*(¹), a similar proposal has received support in some medical quarters. The principal argument appears to be that with the growing complexity of all branches of medicine and surgery there is a greater need for the consultant to have the assistance of someone at an advanced level of specialist training, and therefore a greater need for posts with unlimited tenure for fully trained assistants. It is also claimed that the holding of a post of this kind confers maturity and consolidates the experience desirable in the holder of a consultant appointment.

52. From the foregoing it would appear that consideration of the staffing needs of the hospital service has provided some evidence of a place for a permanent hospital grade above senior registrar and below consultant. The numbers in any such grade would no doubt be limited, since the consultant would remain the essential specialist grade.

53. The following paragraphs examine the grades contemplated in the Spens Report (which do not include the S.H.M.O.) and the experience derived from the use of them in the hospital service since 1948.

(¹) LANCET.	1st June, 1957 (p. 1127 and 1133)	10th August, 1957 (p. 291)
	22nd June (p. 1299)	7th September (p. 486)
	29th June (p. 1352)	14th September (p. 541)
	13th July (p. 92)	21st September (p. 595)
	20th July (p. 144)	28th September (p. 641)
	27th July (p. 187)	5th October (p. 693)
	3rd August (p. 240)	30th November (p. 1099)
		14th December (p. 1227/30)

54. The Spens Committee for Consultants and Specialists regarded the consultant as the basic grade in the hospital medical staffing structure, and this is in fact the case. It is the only grade in which the appointments are of unlimited tenure (subject of course to a specified retiring age), and all other hospital medical staff are assistants of the consultant. In all other grades also the appointments are held on a year to year basis (except in the most junior—the house officer—where they are held on a six monthly basis); and the Terms and Conditions of Service of Hospital Medical Staff postulate that total service in the grades above house officer will normally be—
 one year for senior house officer;
 two years for registrar;
 four years for senior registrar.

55. In size, the consultant grade not only far outnumbers any other grade but outnumbers the senior house officer, registrar and senior registrar grades taken together. The latest available figures for hospital medical staff (excluding S.H.M.Os) relate to 31st December, 1956, and are:—

TABLE 9

		Per cent of total
Consultants	7,363	43·9
Senior registrars	1,299	6·154
Registrars	2,725	
Senior house officers	2,130	
House Officers (mostly provisionally registered doctors but includes a small number of dental house officers) ...	3,270	19·5
	TOTAL 16,787	100·0

Though most consultants are under contract for part-time service only, it is estimated that allowing for this the amount of time covered by the contracts of all consultants would be approximately 5,700 whole-time equivalents. The real difference between the number of consultants and the amount of time in whole-time equivalents which is actually given to hospital work may be less than the foregoing figures suggest; for evidence was given to the Committee of Enquiry into the Cost of the National Health Service that the majority of part-time consultants in fact work longer hours than they have contracted to do (see paragraph 401 (vi) of the Committee's report reproduced in Appendix J to the Factual Memorandum submitted to the Commission by the Health Departments) though on the other hand part-time consultants are also involved in considerably more travelling time (for which they are paid) than are whole-time consultants.

56. Though the Spens Committee for Consultants and Specialists visualised the grades between house officer and consultant as a training ladder which would normally lead within six years or so to consultant posts—indeed the Committee placed all those intermediate grades into the specialist category—experience since 1948 has shown:—

- that in order to provide an adequate staff for the performance of the work of the hospital service, more doctors are required in these intermediate grades than would be needed simply for filling consultant vacancies expected to occur a few years ahead.
- that it is impracticable to gauge consultant requirements in each specialty four years ahead and wastage of senior registrars during training so precisely as to secure a perfect balance between the number of senior registrars completing the recognised term of four years training in the grade and the number of consultant vacancies becoming immediately available for them.

In consequence various measures have been adopted in attempting to reconcile the needs of the service with the concept of a training ladder. First, the junior registrar of the Spens Report ceased to be regarded primarily as a training grade (and was

renamed senior house officer). Later, in 1951, the registrar grade also ceased to be regarded primarily as a training grade. Both these steps were necessary in order to make it clear that the numbers in these grades bore no relation to future consultant vacancies and that the holders of these posts could not all expect to continue up the training ladder. By this time also it had become apparent that the ready availability of assistance for young specialists to undertake further training on demobilisation from the Forces, combined with the steadily increasing staffing needs of the hospital service, had resulted in the number of senior registrars increasing to a figure far higher than that required to fill potential consultant vacancies, in spite of the substantial increase in the consultant establishment. Whereas the total number of senior registrars at the end of 1951 was over 1,500, it was estimated that a sufficient supply of candidates to provide reasonable competition for the anticipated consultant vacancies in the coming years could have been secured by maintaining a senior registrar complement of 1,080. From that time the number of training posts for senior registrars has been fixed by the Health Departments after consultation with the profession; but the number of senior registrars has continued to exceed the number of training posts. Where senior registrars have completed their four year term of training but have not so far succeeded in obtaining higher posts, hospital authorities have been authorised, with the profession's agreement, to retain them as senior registrars, provided the authorities are satisfied that they have consultant potentialities. This excess of senior registrars over the approved number of training posts does not exist in all specialties: it is present mainly in general medicine, general surgery and obstetrics and gynaecology but similar problems occur also in some of the smaller specialties. In some other specialties the number of consultant vacancies has been bigger than could have been foreseen when the control of the number of senior registrar training posts was introduced, and senior registrars in these specialties (among which anaesthetics and radiology are notable) have commonly been able to obtain consultant posts well before completing four years as senior registrars.

57. Altogether some 200 senior registrars have been in this grade for five years or more and are being retained on a year to year basis while they continue to compete for consultant vacancies. It must be wholly exceptional in a public service and perhaps outside it to regard persons who began their professional education fourteen years or more before, who have been continuously employed in the practice of their profession for nine years or more and are of proved ability, as being still in training; to employ them in a temporary capacity only; and to postulate at this stage that they may not obtain permanent employment. In practice it is peculiarly difficult for an employing authority, particularly one with a near monopoly of the available employment, to terminate the services of an officer at this age and at this level of qualification and responsibility. His age and the very fact of his having specialised may make it difficult if not impossible for him to commence again in another specialty even if he had the aptitude, or to change from hospital work to another branch of medicine. At the same time the fact that appointment as a consultant is competitive—which the Health Ministers believe to be essential to the well-being of the service—inevitably means that some competitors will fail to obtain appointment, which in its turn means that in present circumstances a permanent hospital career is closed to them.

58. A further relevant point to be borne in mind is the longstanding difficulty in recruiting into the existing assistant grades enough staff to meet the needs of the hospital service. This problem of junior hospital medical staffing between the consultant and house-officer grades has become and continues to be acute, particularly in the non-teaching hospitals, and discussions with the profession extending over several years have found no solution.

59. The conclusions to be drawn from the points made in the three preceding paragraphs—the difficulty of reconciling the staff requirements of the service with the "training ladder" of the Spens Report; the absence of permanent employment for the trained specialist who fails to obtain a consultant appointment; and the continuing shortage of medical staff below consultant level in the hospitals—would appear to be that experience of the operation of the structure contemplated in the

Spens Report has revealed that it is defective; and that one requirement not met is that of a senior assistant grade without limit of tenure, in which the fully trained specialist could serve until he obtains a consultant appointment, or could find a permanent career if he fails to obtain one.

The system of distinction awards

60. The system of distinction awards is not merely a method of payment. It aims at securing a wide spread of incomes in the specialist service—in the Spens Committee's words "a proper distribution of incomes throughout the entire range of remuneration"—so that more than normal ability may receive adequate reward. It is therefore an important aspect of remuneration, and the question whether the present amounts and proportions are about right can be dealt with only as part of the wider question of what is the right level of consultant remuneration. And since it differentiates between consultants, it has to be considered along with the problem of grading. The system involves additional payments beyond the basic scale to just over one-third (34 per cent) of the consultants—some 2,600 in all. The total amount of these payments on a full-time basis would exceed £2½ millions per annum, but is in fact less to the extent that many of the recipients are employed on a part-time basis and are entitled only to part of the full-time value of their award.

61. The Commission may find it helpful to have set out in Appendix III a summary of the case adduced in the Spens Report for the award system and of views which have since been expressed on it.

62. This system, under which the highest levels of remuneration are payable by reference not to the recognised responsibilities of the posts which the recipients occupy but to the assessed abilities of the individuals, is very exceptional, certainly in a public service involving public funds. It is even more exceptional in that the fact of the payment is not disclosed.

63. The Spens Committee considered that no alternative method would achieve a satisfactory spread of consultants' incomes.

64. The main advantages of the awards system appear to be :—

- (a) Higher remuneration for consultants can be based on individual professional distinction, and does not have to be dependent on mere age, length of service, tenure of particular posts, practice of a particular specialty, etc.
- (b) The system does in general seem to have achieved the object of giving higher rewards for "more than ordinary ability and effort" and to have worked, in a most difficult field, with a considerable degree of acceptance.

65. The system is however open to criticism in certain respects :—

- (a) The method of remuneration by confidential awards obscures the amount of it. For example, the differential between consultants and general practitioners tends to be measured against the consultant's basic scale, whereas the average consultant remuneration (on a full-time basis) is £300 a year higher than the basic scale.
- (b) The hospital authorities who appoint and pay consultants have no voice in determining their ultimate remuneration.
- (c) As the number of consultants increases, it seems open to question whether the proportion meriting distinction awards remains constant at 34 per cent. Numbers have risen from 5,600 in 1949 (already many more than at the time of the Spens Committee's work) to 7,829 at the end of 1957, or by about 40 per cent, and the Willink Committee expects a further increase.

Possibility of some other means of differentiation

66. As already indicated, the Spens Committee concluded that there was no other means of differentiating in remuneration between specialists to take account of

variations in professional distinction; it did not comment on the desirability of differentiating according to the measure of responsibility carried. Although the Report did not discuss the point the Committee evidently assumed that once specialists had attained "staff status" their responsibilities did not significantly vary, either within or between specialties. The Committee recognised (paragraph 4 of the Report) that there were, e.g. physicians and "assistant" physicians but said "when the term 'assistant' is used it does not necessarily imply that the holder of such an appointment is subordinate to the physician or surgeon".

67. The system was intended to recognise diversity of ability and effort among consultants, to take account of special contributions to research, or to medicine in other respects, and to take account also of other outstanding professional work. The question whether this remains the proper basis for higher remuneration should perhaps be considered in the light of the foregoing paragraphs.

68. It has been proposed that responsibility would provide a better measure of remuneration, and Scottish tradition may be of interest in this context. In the larger hospitals in Scotland it has been customary to organise the work, in at any rate the major specialties, in units which are responsible for one or more wards. Within each unit there is a physician or surgeon "in charge" and one or more assistants. The senior exercises a general supervision over the work of the unit as a whole; the assistants are fully qualified and experienced and of "staff status" but they do not have sole charge of beds. The senior posts are recognised as posts "in charge of wards" and they continue to be filled as such, often but not always after advertisement. The tradition has been—and experience since 1948 has only confirmed it—that, other things being equal, the specialists of distinction will gravitate to these posts, with the higher status and responsibility they carry. There has been keen discussion as to whether these posts should always be open to competition, but debate on the method by which the winners should be chosen merely serves to demonstrate the reality of the prizes.

69. The Scottish system does not obtain in England and Wales; and there is in those countries no easily discernible hierarchy of responsibility among consultants which might provide a basis for higher remuneration. For example, in a professorial unit (consisting of a professor, one or more other consultants, and junior medical staff) the professor organises the work and teaching of the unit but does not in any sense supervise or assume responsibility for the clinical work of his consultant colleagues. In the same way, although in certain departments such as pathology or radiology—both in non-teaching as well as in teaching hospitals—where several consultants are employed, one of their number (not necessarily the senior) may be designated as director; he also is not in any sense responsible for the clinical work of his colleagues, but is responsible for co-ordinating the staff and work of the department. It does not appear possible to point in England and Wales to any basis on which remuneration between different consultants could be differentiated by responsibility.

70. Having regard to the above considerations, the Government's view is that the balance of advantage is in favour of a continuation of the present system, though not necessarily with the same number or size of awards; alternative methods hitherto considered for achieving an appropriate spread of incomes are either unsuitable to the circumstances of consultants' remuneration or create more problems than they solve.

Conclusion

71. This consideration of staffing structure, and the examination of the present system of distinction awards, seem to the Health Departments to point in the same direction: towards the establishment of a more realistic staffing structure which would offer a satisfactory career to all trained specialists, and a modification of the awards system to take account of the increased numbers of consultants and of any changes in the staffing structure.

72. It would appear, therefore, that in considering their recommendations for the remuneration of hospital medical staff the Commission will need to take into account two alternatives.

- (a) It may be thought desirable that the present staffing structure should continue unchanged, with the consultant as the basic grade; with no permanent assistant grade apart from the senior hospital medical officer in some specialties; with a senior registrar grade whose size is determined by anticipated consultant vacancies; and with the present junior grades. On this basis the Commission would no doubt evaluate the different grades, including a basic remuneration for the consultant; would then proceed to consider the alternative methods of arriving at the number of consultants who should receive remuneration higher than the basic, of differentiating between them, and of selecting the recipients; and would recommend a maximum level of remuneration together with any intermediate points between the basic and the maximum.
- (b) It also seems desirable to take into account the possibility of changes in the staffing structure, in particular the introduction of a permanent hospital grade above senior registrar and below consultant in all specialties. On this basis the Commission would need in addition to evaluate the new grade, to consider its size, and to take into account the relationship between the remuneration of this grade and the basic consultant scale.

TABLE 10

(PART 1)

Senior Hospital Medical and Dental Officers: England and Wales

Specialty	June, 1953	June, 1954	June, 1955	June, 1956	September, 1957
General Medicine* ...	210	209	221	211	210
Diseases of the Chest ...	334	358	369	381	370
Mental Health ...	350	357	365	381	393
Neurology ...	5	6	6	5	5
Paediatrics ...	20	18	20	19	16
Radiology ...	64	68	64	55	52
Radiotherapy ...	32	34	37	37	36
Physical Medicine ...	22	21	25	26	25
Pathology ...	142	156	159	170	171
Infectious Diseases ...	66	67	68	71	65
Dermatology ...	43	41	36	32	31
Venereology ...	72	72	75	72	70
Ophthalmology ...	222	245	227	230	239
General Surgery ...	200	188	197	188	183
Anaesthetics ...	274	264	274	269	265
Neuro-Surgery ...	1	1	1	1	1
Plastic Surgery ...	1	1	1	1	1
Thoracic Surgery ...	1	1	—	—	—
Orthopaedic Surgery ...	42	46	55	59	56
Dentistry ...	223	226	228	230	239
Ear, Nose and Throat ...	34	34	31	33	32
Obstetrics and Gynaecology...	90	87	87	83	78
Totals ...	2,448	2,500	2,546	2,554	2,538

*Includes appointments in geriatrics.

TABLE 10
(PART 2)
Senior Hospital Medical and Dental Officers: Scotland

Specialty	December, 1953	December, 1954	December, 1955	December, 1956	September, 1957
General Medicine*	13	16	23	23	22
Diseases of the Chest	54	58	62	67	67
Mental Health	41	44	43	42	44
Neurology	1	1	1	1	1
Paediatrics	3	5	5	5	5
Radiology	14	14	14	10	9
Radiotherapy	4	3	3	4	5
Physical Medicine	—	—	1	1	1
Pathology	17	21	23	22	26
Infectious Diseases	8	9	9	9	9
Dermatology	8	8	8	8	7
Venereology	8	8	8	8	8
Ophthalmology	19	19	23	23	25
General Surgery	17	17	16	16	15
Anaesthetics	44	47	47	45	45
Neuro-Surgery	—	—	—	—	—
Plastic Surgery	—	—	—	1	1
Thoracic Surgery	1	1	—	—	—
Orthopaedic Surgery	13	14	15	15	17
Dentistry	33	33	34	33	35
Ear, Nose and Throat	3	5	5	5	6
Obstetrics and Gynaecology... ..	15	14	13	13	13
Totals	316	337	353	351	361

* Includes appointments in geriatrics.

(7) The weight which in the Government's opinion should be given in considering remuneration to the following and any other special features (in so far as they may in fact be special features) of the medical profession :

- The need to maintain a good social position*
- The need to avoid financial anxiety*
- The length and cost of training*
- Responsibility for human life*
- Long and irregular hours of work*
- Being on call at night*
- Special risks to health*

(8) Views on the extent to which the same or other features may apply to the dental profession.**The Medical Profession**

73. In general, the Government takes the view that all the factors enumerated in this question should be considered in comparison with conditions in other professions, with the object of ensuring that the medical profession attracts a proper share of recruits of the right calibre in competition with other careers. Assuming that the level of professional remuneration of doctors is fixed as contemplated in the Commission's terms of reference on the basis of fair comparison with the remuneration of other professions and connected occupations, the factors in (a) and (b) of this question, which are in no way peculiar to the medical profession, will take care of themselves. While the Spens Committee on Remuneration of General Practitioners specially mentioned the effect which financial anxiety might have on a doctor's work, this arose from the Committee's conclusion that, at the time covered by their inquiry, the percentage of low incomes among general practitioners was too high.

74. The length and cost of training and the age when doctors in consequence start earning are factors which should certainly be taken into account in assessing remuneration; but here again the basis should be that of comparison with other professions. Medical training, while long, is not unique in its length and, below the income level fixed for the purpose, the State Scholarships and Local Education Authority Awards now available for higher education and for professional training have considerably reduced or eliminated the cost falling on the student or his parents (see Appendix IV paragraph 7 for illustration). The factor therefore needs to be considered in the light of similar information about other professions. Some examples are cited in Appendix IV and no doubt the Royal Commission will be in possession of more detailed information about these and other professions. Some information on cost and length of training and financial assistance during training is also given in Appendix IV.

75. The weight of responsibility for human life varies in the several branches of the profession and from one day to another. Doctors concerned with medical administration carry a general, somewhat impersonal, responsibility for the community which at times of epidemics may admittedly be heavy. The difference in this type of responsibility and that borne by the clinician is reflected in their remuneration. But the responsibility for individual lives falls more particularly on general practitioners and specialists. It is a responsibility from which the general practitioner is never wholly free, though it may differ greatly in intensity and frequency. There are a few specialties in which this responsibility arises only infrequently. There are others in which it is constantly present, and of these surgery and particularly its advanced forms—neuro-surgery and thoracic surgery—are the outstanding examples, though obviously the physician can and does carry in many cases just as great a burden. But responsibility for human life is not carried only by the medical profession. Captains and masters of ships at sea, the pilots of aircraft, officers of the Armed Forces are examples of professions where responsibility is heavy, varying in degree according to circumstances, but at moments of crisis very onerous indeed.

76. The features of long and irregular hours and of being on call at night should clearly be given weight in considering remuneration. Here again, they are not exclusive to the medical profession and their incidence within the profession varies widely. The pressure on the general practitioner is far heavier in winter than in summer: it is to some extent diminishing with the growth of partnerships, group practice, rotas and other arrangements of this kind: senior hospital doctors have fairly regular hours for National Health Service work, and in some specialties at any rate are exposed to little risk of night calls.

77. The Government is unaware of any conclusive evidence that the profession suffers from special occupational risks to health. In the matter of mortality the Government Actuary recently stated, in a memorandum printed as Appendix 3 to the Willink Report:—

"a study of occupational mortality statistics . . . shews that in some years and . . . age groups the death rates experienced by . . . the medical profession have been somewhat less than those of the population in general, while in other years or in other age groups they have been somewhat greater. The differences are fairly small in all cases . . ."

The Registrar-General for England and Wales has informed the Health Departments that the Government Actuary's findings will be confirmed (for dentists as well as for doctors) by the analysis of occupational mortality for 1949-1953 which will be published shortly. The Registrar-General is willing to prepare a special note on doctors' (and dentists') mortality if the Commission so desire. Some statistics of mortality among male doctors, dentists and veterinary surgeons as compared with all males in Scotland are given in the Annual Report of the Registrar-General for Scotland, 1955, and the Registrar-General for Scotland will consider whether he can provide further information on the subject if the Commission wish.

78. In regard to morbidity, the British Medical Association contend in their Preliminary Memorandum of Evidence that doctors, especially general practitioners, suffer more than average from heart disease. Neither the Registrar-General for England and Wales nor the Minister of Pensions and National Insurance has any

reliable figures throwing light on this question. Contentions about one disease are, however, inconclusive in this connection unless account is also taken of other diseases in which the opposite might be the case.

79. The Medical Research Council research report (No. 276) on "Occupational Factors in the Aetiology of Gastric and Duodenal Ulcers" shows that of 127 doctors interviewed the number of ulcers was more than twice the number expected. But after discussing the criteria of diagnosis the report suggests that greater refinement of diagnosis was the explanation of the excess and that there was no justification for concluding that doctors are more likely to get ulcers than the general population (pages 46-49 of the Report).

80. It is possible that this explanation might account for the apparent higher rate of heart disease to which the British Medical Association draw attention.

81. The only certainty about this question of relative morbidity in relation to disease generally is that definite conclusions cannot be drawn on present evidence. In so far, however, as mortality may be an index to morbidity, the indications are that doctors' morbidity for all diseases taken together is little, if any, greater than that of the population as a whole.

82. The Government is not aware of any other features to which attention should be drawn.

The Dental Profession

83. Much of what is said above about doctors applies in substance to dentists also. A dentist, however, does not carry responsibility for human life in the same sense as a doctor: he does not have such irregular hours of work as a doctor in general practice and is not exposed to the same risk of emergency calls at night and at the weekend.

(9) The Government's views on what factors should be taken into account in determining the relativities in remuneration between—

- (a) *general medical practitioners and general dental practitioners;*
- (b) *general medical practitioners and specialists in hospitals; particularly whole-time specialists;*
- (c) *general dental practitioners and dental specialists;*
- (d) *part-time and whole-time specialists.*

84. In the Government's view the fundamental relativity is that between the whole-time medical specialist and the general medical practitioner. Once this has been established the other forms of medical and dental practice in the National Health Service can be related to one or other of these two. This paper therefore considers relativities in the following order:—

- (a) *whole-time medical specialist in hospital and general medical practitioner;*
- (b) *general medical practitioner and general dental practitioner;*
- (c) *whole-time medical specialist and whole-time dental specialist;*
- (d) *whole-time specialist and part-time specialist.*

Specialist and general practitioner

85. The factors to be taken into account are:—

- (a) *the age at which the status of a specialist in the hospital service or a principal in general practice is achieved;*
- (b) *the pattern of earning over the period of professional activity as a specialist or principal;*
- (c) *differences in demands on professional skill and experience;*
- (d) *other differences in the conditions of employment.*

86. *Age at which status of a specialist or of a principal in general practice is achieved.* Up to full registration the training of future specialists and general practitioners is the same. After full registration the aspiring specialist must undergo a period of post-graduate training—which may be long—before he is likely to have much chance of obtaining a permanent senior post in hospital. This training is acquired in several short-term posts, filled on a competitive basis, which normally occupy as much as seven years and often more. During this period he will usually obtain a higher qualification or specialist diploma in his chosen specialty by passing a difficult examination and in many cases will also obtain a higher degree by submitting a thesis and/or by examination. The doctor who intends to become a general practitioner can, in theory, enter general practice immediately after full registration. In practice, however, he sometimes spends a further period, of one or more years, in junior hospital posts, followed as a rule by two or more years as assistant to a principal. Information about the age at which doctors in England and Wales become specialists in hospital or principals in general practice is given in the Health Departments' Factual Memorandum at page 28 (for specialists) and Appendix T (for general practitioners). On the basis of these figures the mean age of appointment to a consultant or S.H.M.O. post is between 36 and 37 and the normal age of entry to general practice as a principal is between 30 and 35. (The figures for general practice relate only to doctors who became principals after a period as assistants; for doctors who became principals without a preliminary assistantship the age of entry might have been lower.)

87. The termination of National Service may in due course reduce the age at which doctors take up their permanent places in practice of different kinds but not to affect the relativity between hospital doctors and general practitioners.

88. *Pattern of earning.* The series of short-term posts in which the potential specialist will normally spend his training years carry salaries ranging from £467 10s. a year for the provisionally registered practitioner entering upon his first house post to £1,540 a year for the senior registrar in his fourth or later year. When appointed to a consultant post he proceeds by regular increments over eight years to his maximum.⁽¹⁾ During this period, or at any time after he has reached his maximum, he may also receive a distinction award (or having received one award may be promoted to a higher category). The general practitioner will begin as a house officer and may stay in the hospital service until he reaches an appointment in one of the registrar grades and then generally takes a post as an assistant in general practice. When he becomes a principal his income will depend on the size of the practice. If he becomes a single-handed principal in an established practice, his income may well be substantial from the outset. If he enters a partnership he will receive a lower proportion of the partnership profits during his early years, but should normally reach parity or near parity with his partners after between five and ten years. Although the number and geographical distribution of general practitioners is changing, the consequent changes in the size of list and, hence, income of individual practitioners are likely to be slight and gradual. At present most newly qualified doctors suffer a break of two years in their civil employment, after becoming fully registered, while they do their National Service.

89. *Skill and experience.* Where the kind of work differs so widely as it does between specialist and general practitioner it is difficult to establish relative levels of skill and responsibility. On the one hand the specialist may be said to have a higher degree of knowledge and skill in his particular field, and in some cases may use more advanced and delicate techniques; but his skill is exercised in a narrower field than that of the general practitioner. The specialist has to keep himself fully informed of all advances in his own specialty and many in related specialties; but a good general practitioner—with fewer facilities and more distractions than the specialist—must keep in general touch with progress over the whole range of medicine, so that he can not only give his patients the best possible service within his own competence but knows when to refer them for

⁽¹⁾ He may reach his maximum in less than eight years if appointed after the age of 32 and given a starting salary above the minimum of the main scale on the grounds of age, qualifications and experience.

specialist advice or treatment—a decision which will often be finely balanced and may well be critical. Because the more dangerously ill patients are admitted to hospital, the daily work of the specialist is likely to include a higher proportion of cases where life may be in the balance and a wrong decision could prove fatal. On the other hand, the specialist is supported by junior medical staff, has specialists in other specialties readily available for consultation, and is able to call for special methods of investigation as well as having the constant assistance of a team of nurses and medical auxiliaries.

90. *Other conditions of employment.* The consultant's hours are in general more regular than the general practitioner's and he is exposed to less risk for emergency calls (though this last risk undoubtedly depends on the specialty in which he is practising, being greater for, say, surgery and anaesthetics and less for, say, dermatology). Moreover the general practitioner has a continuing responsibility for the health and welfare of his patients and their families; he is the "front line" of the medical services and has usually to cope with the first impact of accident or disease; and on his judgment will depend access to the right method of treatment and often the future prospects of recovery.

91. Although the general practitioner no longer has to buy his practice the initial expenses of establishing himself are likely to be higher than for a whole-time hospital doctor. Not only must the general practitioner supply his own professional equipment but he must provide himself with a house and with consulting premises suitable for the needs of his practice, either in his own house or separately. For the purposes of his employment in the National Health Service the hospital doctor has to provide neither surgery accommodation nor professional equipment. Further he is able to conduct some of his private practice in hospital premises, the maintenance costs of which are borne in the charges paid by the private patients. A consultant who uses his own electrocardiograph or portable X-ray apparatus in the cause of a domiciliary visit under the National Health Service receives a fee of 2 guineas in addition to a fee of 4 guineas for the consultation itself.

92. It is, of course, difficult to evaluate such imponderable considerations as these. On balance it seems to the Departments that on the present career structure in both fields the longer training of the specialist, the later age at which he attains full professional status, and the fact that in his own specialty he is a "consultant" in the proper sense, to whom the general practitioner applies when in doubt or difficulty, justify some differential over the general practitioner, as is in fact at present given by the present system of remuneration.

93. It is not easy to find a satisfactory basis for comparing the present levels because of the different systems of remuneration. The average earnings of a whole-time consultant over the last 25 years of his professional life, from 41 to 65, are estimated at approximately £3,200 a year on the assumption that he reaches consultant status at 36; if to this is added £370, representing the average value⁽¹⁾ (on a whole-time basis) of the number of distinction awards held by consultants over 40, the total average income becomes £3,570. The average net income from all sources of general practitioners over the same period of their career is not known, but it is likely to be greater than the £2,333 average for all general practitioners of all ages. The average gross income from all public sources in 1955-56 was £3,476 for general practitioners between 40 and 64, compared with £3,246 for general practitioners of all ages (excluding in each case partners whose partnership share is not known⁽²⁾). For all ages the current average net income is £2,333 (including the Exchequer superannuation contribution) and this, together with the foregoing information on gross incomes suggests that for the 40-64 age

(1) Average value here means the total whole-time value of awards held by consultants over 40 divided by the total number of consultants over 40.

(2) The income/age distribution is unknown for doctors in partnerships where the shares are unknown. Assuming that this distribution is similar to that for partnerships where the shares are known it is likely that inclusion of these doctors in the calculation in para. 93 would have the effect of raising slightly the current average net income above £2,500.

group the current average net income is about £2,500. After deducting the Exchequer superannuation contribution in order to produce a figure comparable with that given above for the consultant, the general practitioner's net income becomes about £2,320 or £1,250 less than that of the consultant. On this basis, the differential in the consultant's favour amounts to more than 50 per cent of the general practitioner's net remuneration.

General medical practitioner and general dental practitioner

94. The entrance qualifications to a dental school are the same as for a medical school. The period of professional study is, however, usually a year shorter for dentists than for doctors. Evidence from the Ministry of Labour and National Service—see Appendix L to the Factual Memorandum—indicates that the age of qualification varies mainly between 23 and 25 for medical students and between 22 and 24 for dental students (disregarding those who did National Service before going to their medical or dental school).

95. The holding of house appointments in hospital before entering general practice is not general or usual in dentistry as it is in medicine (see paragraphs 86 and 87 above), but many newly qualified dentists work for a time as assistants before setting up in practice on their own. The information set out in Appendices T and U to the Factual Memorandum shows that the average age at which a dentist becomes a principal is much lower than for general medical practitioners.

96. As regards conditions of work and responsibility there are important differences between medical and dental practice. From the very nature of his work a medical practitioner's responsibilities are potentially heavier and more onerous than those of a dental practitioner. Moreover, although his chairside work involves a more intensive strain, the conditions of work of the general dental practitioner are more regular in that he can work to fixed hours and at his own surgery, whereas more of a general medical practitioner's time is spent in visiting patients in their homes than at his surgery and he is always liable to be called out at any hour of the day or night. The general medical practitioner has a continuous responsibility towards every person on his list, to which there is no counterpart in the case of a general dental practitioner.

97. Some allowance, on the other hand, should be made for the necessary capital outlay which has to be borne by a dentist starting practice. Equipment for a modern surgery and workshop will run into four figures and with properly furnished rooms and office might amount to £2,000.

98. Moreover, the McNair Committee on Recruitment to the Dental Profession quote figures suggesting that after the age of 45 incomes decline sharply. The Committee pointed out that they knew of no other profession in which such a pattern of earnings obtained.

99. Since the commencement of the National Health Service the value of a dental practice on transfer has fallen considerably. Indeed it is said to be difficult to sell a dental practice.

100. Although these factors cannot be precisely evaluated, it is the Government's view that there is an undoubted difference between the responsibilities of the general practitioners of the two professions and that, as the Spens Committee on the Remuneration of General Dental Practitioners concluded, a differential in favour of the general medical practitioner is clearly justified. Appendix V indicates the degree of difference which has prevailed at different times since the establishment of the National Health Service.

Medical Specialist and Dental Specialist

101. It does not seem necessary to compare in detail the work and responsibilities of medical and dental specialists, since in the Departments' view the difference between the work of a dental specialist and that of a medical specialist is no more significant than the difference between the work of different medical specialists. Since the establishment of the National Health Service dental consultants and senior hospital dental officers have ranked equal with their medical colleagues.

Whole-time and part-time specialist

102. Considerable criticism has been voiced about the disparity between the bases of payment to whole-time and part-time Consultants in the Hospital Service. These issues were considered by the Guillebaud Committee in paragraphs 398 to 404 of their Report, and the Committee expressed the opinion "that it is undesirable that the financial arrangements relating to the Consultant service should be such as to provide a financial inducement to a Consultant to apply for a part-time rather than a whole-time appointment".

103. The main causes of this disparity at the time of the Guillebaud Committee's deliberations were:—

- (a) The inclusion of travelling time (up to a maximum of half an hour each way to and from his main hospital) in the *paid sessions* of the part-timer, and the payment of his travelling expenses to and from home (up to a maximum of ten miles each way).
- (b) The payment to part-time Consultants, but not to whole-time Consultants, for domiciliary visits and
- (c) The adjustments made in favour of the part-time Consultant when computing the number of notional half-days on which his salary is reckoned. After the average number of hours required by the average practitioner to perform the duties attaching to the part-time post have been assessed, that number of hours is then converted into notional "half-days" per week by dividing by $3\frac{1}{2}$. If the resulting figure is fractional it is adjusted to the next highest whole number.

e.g. 15 hours divided by $3\frac{1}{2}$ = $4\frac{2}{7}$. Counted as 5 notional "half-days".

(See paragraph 39 of the Health Departments' Factual Memorandum.)

- (d) The weighting in favour of part-time Consultants, as compared with the whole-time basic rate, in the calculation of the salary to be paid for these notional half days. (See paragraph 40 of the Health Departments' Factual Memorandum.)

These questions are discussed separately in the succeeding paragraphs.

104. The previously existing disparity between part-time and whole-time Consultants in respect of domiciliary visits has been reduced as the result of agreement reached in 1955, whereby broadly speaking the same payments may be made to part-time Consultants as to whole-time Consultants subject, however, to no payment being made to the former in respect of the first eight domiciliary visits made in any quarter.

105. The weighting adopted in the calculation of remuneration of part-time Consultants is described in paragraphs 39 and 40 of the Factual Memorandum. It applies to Senior Hospital Medical Officers and Senior Hospital Dental Officers as well as to Consultants. The arrangements for weighting stem from the recommendation of the Spens Committee for Consultants and Specialists that the part-time Specialist should be paid rather more than the appropriate proportion of the whole-time rate. The Committee's view was that:—

"... the responsibilities and commitments of a part-time appointment cannot be measured in relation to those of a whole-time appointment simply by comparing the total working hours of the part-time officer with the total working hours of his whole-time colleague. The specialist who holds a part-time hospital appointment has a continuous responsibility for the patients in his charge, which must extend beyond the limits of the time he contracts to serve: further, he will be expected to take his share in the committee work of the hospital, and this must encroach upon time which would otherwise be spent in private practice. In assessing the remuneration which shall attach to part-time appointments such factors must be taken into account." (Section 15 of the Report.)

106. The Government consider that there is no longer justification for this more favourable basis of payment for part-time Specialists. The Consultant who wishes to continue with private practice should not be more favourably treated than one who devotes his whole time to the National Health Service. The continuous

responsibility for patients applies just as much to the whole-time Consultant as to the part-time Consultant; so also participation in Committee work is expected of the whole-time Consultant as of the part-timer. In any event Specialists who spend their own time in Hospital Committee work, whether at the expense of remunerative practice or of leisure, should not be in any more favourable position in this respect than lay members of Committees.

(10) Any information which the Government may have about private earnings of:—

- (a) *general medical practitioners*
- (b) *general dental practitioners*
- (c) *part-time hospital specialists*

In particular, the Commission would be glad to know whether the Government consider the estimate of £2 million for private earnings of general medical practitioners used in the calculation of the Central Pool is reasonable.

107. The Government has no information about these earnings to place before the Royal Commission and subject to what is said in paragraphs 109 and 112 below it knows of no source, other than the practitioners themselves, from which direct information of the actual amount of such earnings might be obtained.

General Medical Practitioners

108. The figure of £2 millions has been used in the calculation of the Central Pool with effect from 5th July, 1948, because Mr. Justice Danckwerts adopted it in his award relating to the Pool for 1950-51. The same figure was used for the Pool for 1951-52 but in subsequent years it has been used on a provisional basis only and on the strength of an understanding with the profession that should it be found by enquiry that as a result of its use doctors have been underpaid or overpaid an appropriate adjustment would be made later, either in favour of the doctors or of the Exchequer as the case might be. Its use in the calculation of the Pool for the years in question must not therefore be taken as implying that the Government considers it to be a correct figure for those years. Without access to later data the Government is not in a position to form an opinion on its continued reasonableness.

109. The Board of Inland Revenue extracted data from the Income Tax returns for 1952-53 of a stratified sample of doctors to ascertain practice expenses for that year. (A summary of this data, which is all on an anonymous basis, has already been supplied to the Commission at their request with the agreement of the Board of Inland Revenue and the British Medical Association.) The Government understand that an estimate of private practice earnings (including fees for life insurance examinations, for giving anaesthesia for dental operations, for factory and industrial medical services not remunerated from public funds, etc.) could be made with the aid of this data. The method the Government had in mind is outlined in Appendix VI. The British Medical Association however dissent on the grounds that it is statistically unsound to use data from a stratified sample taken for one purpose as a basis for an estimate for a different purpose.

110. When the British Medical Association agreed to Income Tax figures being used for ascertaining practice expenses they informed the Inland Revenue and the Ministry of Health that they could not agree to the figures being used for any other purpose. The Association as at present advised feel unable to consent to this data being used to estimate earnings from private practice, and the Government therefore suggests that the Commission may wish to explore the matter further with the Association to see whether there is any way round these objections.

111. A similar inquiry to ascertain practice expenses is being made for 1955-56 and the results will be available shortly.

General Dental Practitioners

112. Data on professional income which is available for 1952-53 for a statistical sample of dentists who were then providing general dental services under the National Health Service might enable an estimate to be made of the total income of all such dentists from private fees. The Health Departments have had no

occasion to examine this question in detail since earnings from private practice are not a separate element in the arrangements for the remuneration of dentists as they are in the arrangements for the remuneration of general medical practitioners. If the Commission desire the question to be examined, the Departments will open discussions on it with the British Dental Association, whose agreement to the figures being used for the purpose would be necessary.

113. Similar data is not available for a more recent period.

Part-time Hospital Specialists

114. There has been no similar enquiry which would enable an estimate to be made for part-time hospital specialists.

(11) The effect on the standards of professional work and service of the present method of remunerating general medical practitioners; and how far it succeeds in rewarding diligence and efficiency.

115. It is assumed that the Royal Commission have chiefly in mind here the system of capitation fees. General practitioners as a body have accepted collective responsibility for treating all members of the public and the capitation system, i.e. the payment to each doctor of an agreed amount in respect of each patient accepted on his list, has been adopted as the simplest means of measuring each doctor's volume of work and hence his entitlement to remuneration. The acceptance of a patient is the acceptance of a responsibility and it is for accepting this responsibility that the doctor is paid. The system also has the fundamental advantage that it pays the doctor to keep his patient well and that it does not give him any incentive to multiply his items of treatment for the sake of increasing his income.

116. There are no objective tests whereby one can judge the effect of the system on standards of professional work and service or its success in rewarding diligence and efficiency, but it may help the Commission to have the following comments on some of the criticisms which have been made of the system:

- (a) That it encourages doctors to take on too many patients. This danger is very largely safeguarded by limiting the size of lists, by making a medium-sized list relatively more rewarding than a maximum list (by loading payment on the range of patients between 500 and 1,500) and by special mileage (and inducement) payments in areas which are particularly sparsely populated. The volume of the complaints reaching Executive Councils and the Health Departments gives no indication that patients on large lists in particular are dissatisfied with the standard of service they receive.
- (b) That it encourages doctors to refer patients to hospital instead of providing treatment themselves. This possibility is inherent in any system which does not relate remuneration directly to actual work done; and an alternative system would have its own disadvantages, e.g. if based on items of treatment, it would give a financial incentive for their unnecessary multiplication.
- (c) That it does not take sufficiently into account differences in practice conditions and expenses, e.g. topography of the practice area, density of population, rates of morbidity, age distribution of the patients, availability of hospital facilities, etc. In the present method of distribution some account is already taken of topography and density of population by arrangements for mileage payments and inducement payments in areas which are particularly sparsely populated. The practical difficulties of trying to reflect in the distribution of remuneration a great many more variables are obvious and have been discussed in Section XII of the Report of Lord Cohen's Committee on General Practice. But further modifications of the present method of distribution could no doubt be worked out. It is a matter of striking the proper balance between modifications to reflect special circumstances on the one hand, and speed and simplicity of the procedure for paying out remuneration on the other.

- (d) That it does not take into account the doctor's age, experience and efficiency. It is true that no direct account is taken of these factors but broadly speaking they can be presumed to be reflected at least to some extent in the doctor's success in attracting and retaining patients. (Age and experience are of course not necessarily an index of efficiency.) The position is also affected by partnership agreements, which provide for the distribution among the partners of the income of the partnership, and have tended up to the present to increase the rewards of the senior, more experienced partners in relation to the rest.

117. In brief, payment by capitation fee rewards diligence and efficiency in so far as it is by these qualities that a doctor may expect to increase his list and thus his remuneration. The system is not without its disadvantages but these are thought to be less than those of other alternative methods of remuneration so far considered.

(12) The Government's views on the advantages of partnerships between general medical practitioners, and how far membership of a partnership ought to affect a practitioner's remuneration.

118. The advantages of partnership (and group practice) among general medical practitioners may be summarised as follows:—

- Partnerships are one remedy for professional isolation which was said to be one of the special difficulties of general practice at the outset of the National Health Service. The advantage derives from the regular interchange between the partners of new information from reading, other professional contacts, and the introduction at long intervals of a new partner from post-graduate hospital work. Consultation between partners makes it possible for them to provide a better service to the patient.
- Partnership facilitates minor specialisation which again may be of direct benefit to the patient.
- Better premises and equipment and ancillary staff may be provided for the patient at relatively less expense to the doctors concerned.
- Doctors in partnership find it easier to hold additional appointments, e.g., in hospitals, and this again may benefit the patient by improving the general quality of the practice.
- Conditions of practice are less onerous for the doctor owing to the better opportunities for collaboration in arranging off-duty time, holidays, etc., and for the allocation of work to meet special circumstances which may arise from temporary disability or reduced physical capacity.

119. On account of these advantages, it has been the policy of successive Governments to encourage partnerships and group practice. Financial inducements have been provided in the following ways:—

- Entry into partnership is the usual method of entry into general practice as a principal. The provision for partners to be paid loadings on the most profitable division of their patients between them (notional lists) was in fact introduced in order to give an incentive to a practice to admit a new partner. The financial advantage of this provision is illustrated in the following table:—

TABLE 11
Number of loadings on basis of "notional lists"

Number of Patients	Single-handed	Loadings	Partners	Loadings	Partners	Loadings
2,000 ...	1	1,000	2	1,000	—	—
2,500 ...	1	1,000	2	1,500	—	—
3,000 ...	1	1,000	2	2,000	—	—
3,500 ...	1	1,000	2	2,000	3	2,000
4,000 ...	1	1,000	2	2,000	3	2,500
4,500 ...	1	1,000	2	2,000	3	3,000

Thus, a partnership of two with 3,000 patients gets 1,000 loadings (£575 a year) more than the single-handed doctor with the same number of patients, and the partnership of three with 4,500 gets 1,000 loadings (£575 a year) more than the partnership of two with the same number of patients. Put in another way, a partnership of two with a list of 4,500 have an income from capitation fees and loadings of £5,087 10s. 0d. If they take on another partner their income rises to £5,662 10s. 0d. for the same number of patients—an increase of £575 divided between the three doctors. These increases are, of course, in the partnership's share of the central pool and not in the total remuneration of general practitioners.

This system of loadings and notional lists was introduced in April, 1953. The increase since that date in the number of doctors in partnerships in England and Wales and Scotland is shown below:—

<i>Total number of Principals in Partnership</i>					
<i>England and Wales</i>					<i>Scotland</i>
1952	...	...	...	9,745	1,269
1953	...	...	...	10,863	1,404
1954	...	...	...	11,583	1,479
1955	...	...	...	12,068	1,544
1956	...	...	...	12,514	1,614

This represents a rise in the percentage of principals in partnership from 56.6 per cent to 65.6 per cent in England and Wales and from 53.8 per cent to 63.3 per cent in Scotland.

- (b) The terms of reference of the Working Party on the Distribution of Remuneration among General Practitioners set up in 1952 included the stimulation of group practice (this has been taken normally to mean the collaboration of three or more general medical practitioners with appropriate ancillary help at common surgery premises). Following the Working Party's recommendation a sum of £100,000 has been set aside annually from the Central Pool to provide interest-free loans for the improvement of premises for group practice. By the end of 1957 loans had been approved to the totals of £528,396 for 116 group practices in England and Wales and £66,300 for 37 group practices in Scotland.

120. The Government desire to continue to encourage the formation of partnerships (or group practice) and no objection is seen to membership of a partnership continuing to affect remuneration as it has done hitherto.

(13) Views on the desirability of maintaining the existing arrangements for the employment of assistants; and on possible alternatives such as some kind of fixed salary range or scale.

Assistants in general medical practice

121. Assistants to general medical practitioners are appointed by their principals and the relationship between the two is personal and professional. The principal remains responsible, under the Regulations governing the Service, for the acts and omissions of his assistant. This is a traditional arrangement which it would not seem desirable or practicable to try to alter.

122. The main possibilities of abuse of the present arrangements are alleged to be:

- that some principals may employ a succession of assistants with a view to partnership which never materialises;
- that harsh conditions are sometimes offered to assistants;
- that some assistants are asked to undertake an undue share of the work, for which the Principal has undertaken responsibility.

123. The Government has no conclusive evidence of these alleged abuses. There are, however, already in existence some quite considerable safeguards for the assistant, quite apart from the fact that no assistant is obliged to accept unfavourable terms or conditions. Any general practitioner wishing to employ an assistant for more than three months must obtain the consent of his local Executive Council who, in consultation with the Local Medical Committee, have power to review

and, if necessary, to withdraw their consent. The number of additional patients allowed to the principal in respect of his employment of an assistant may also be reduced by the Executive Council, in consultation with the Local Medical Committee, if they think fit.

124. It has been suggested in some quarters that as a further safeguard a principal should not be allowed to employ an assistant for more than, say, two years and that after that period he should have to take a partner or work single-handed. This would, however, seem to be an arbitrary interference in a professional relationship. Moreover, it would not take into account the fact that some doctors prefer to remain assistants, so as to be paid a salary and to have rather less responsibility.

125. Conditions vary greatly between one doctor and another, and it would be difficult to impose upon principals in general practice a fixed salary range for assistants that would suit all circumstances. The difficulties could no doubt be overcome but care would have to be taken not to introduce undue rigidity and a considerable margin would have to be left for variable factors. The most satisfactory arrangement might be an agreement within the profession to observe certain conditions of employment of assistants which would avoid the necessity for writing them into the regulations laying down the terms of service for principals.

Assistants in general dental practice

126. Assistants to general dental practitioners are also appointed by their principals and their terms and conditions of appointment are settled by mutual agreement. If a particular assistant is employed for more than three months the principal is required to notify the local Executive Council but there is no official control over his employment. As with general medical practitioners the acts and omissions of a dental assistant are the responsibility of his principal.

127. Owing to the general shortage of dentists, newly qualified dentists who in other circumstances might be expected to take an appointment as an assistant in their early years of practice find it relatively easy to set up on their own. Because of this not only is it known to be difficult for a principal in dental practice to obtain the services of an assistant but many such engagements are very short-lived. In these circumstances it is also not surprising to find that various forms of inducement are being offered to practitioners willing to serve as assistants and it is known that these often take the form of a bonus or payment of commission on work done. Both these forms of payment put a premium on speed and to this extent they are undesirable. Nevertheless, under present circumstances with a serious shortage of dentists it would scarcely be possible to prevent such arrangements.

128. As with doctors the most satisfactory way of regulating the conditions of employment of assistants might be by way of agreement within the profession.

(15) The Government's view of

- (a) *what should be the number of patients which should be taken as a norm in practices of different kinds for general medical practitioners (i) in partnership, (ii) in single-handed practice; and which should be the basis of the earnings of the average practitioner;*
- (b) *the number of chairside hours which in the light of experience since 1948 can reasonably be expected of the average general dental practitioner at different ages.*

General Medical Practitioners

129. It is not thought to be practicable to try to lay down theoretical norms for various different types of practice which could form the basis of the earnings of the average practitioner in each. It would be exceedingly difficult to determine the number of patients which should be taken as a norm in each type of practice; even when the practices which are very small, or otherwise very exceptional, are excluded, both practices and practitioners vary significantly in ways that affect the number of patients that the practitioner is able or willing to handle. While some practitioners look after a maximum list of 3,500 patients, others are fully employed in looking after considerably smaller lists. There are variations, for

example, in the geography of the practices, in the age distribution and morbidity of patients, and possibly in the calls they make on practitioners. On the other hand, practitioners themselves vary not only in age and state of health but in their methods of practice and in their practice organisation.

130. It is, however, possible to work out from the statistics published in the Annual Reports of the Health Departments the actual average sizes of lists in practices of different types distinguishing between single-handed practices and partnerships of various sizes, between rural, semi-urban and urban areas, and between areas classified by the Medical Practices Committee as designated, intermediate and restricted. The distinction between semi-urban and urban is not very significant though it is used as part of the classification for the making of mileage payments; in fact the average number of patients is higher in the lists of doctors in semi-urban than in urban areas. The classification of areas by the Medical Practices Committee changes from time to time and does not reflect a permanent state of affairs. The difference in types of practice area is, however, already taken into account to a very considerable extent by special mileage (and inducement) payments. In the following analysis a distinction is, therefore, made only between single-handed practice and partnerships of various sizes.

TABLE 12

Type of Practitioner	Average size of list (to nearest 50) in 1955-56	
	England and Wales	Scotland
Single-handed	1,950	1,600
Single-handed with assistant	3,600	3,100
In partnership of 2	2,250	1,950
In partnership of 3	2,350	2,100
In partnership of 4	2,550	2,300
In partnership of 5	2,550	1,900
In partnership of 6 or more	2,400	2,550

The overall average for principals is 2,250 in England and Wales and 2,000 in Scotland (this includes patients who are on their lists but looked after by their assistants).

General Dental Practitioners

131. The scale of fees in force at the introduction of the National Health Service in 1948 was based on the 33 chairside hours per week assumed by the Spens Committee on the Remuneration of General Dental Practitioners to represent "full but not excessive" employment. The incomes earned on this scale greatly exceeded the level contemplated by the Committee and led to the conclusion that the number of chairside hours, or the timings of dental operations, on which the scale was based, or both, differed considerably from what was happening in practice under the National Health Service.

132. The Penman Working Party was accordingly set up in 1949 to establish the facts. Their enquiry showed that the average number of chairside hours per week worked at that date by all dentists in the sample covered by the inquiry was 36.1. Excluding the three groups of dentists with the lowest time (who were presumed not to be in whole-time practice) and the two groups with the highest time (who seemed to be working considerably longer hours than they were likely to continue), the average was 37½ hours. (Report of the Working Party on Chairside Times, p. 15, Table 5.)

133. The scale of fees now in operation is not based on any fixed figure of chairside hours per week.

134. The information in possession of the Departments is insufficient to enable a view to be expressed as to the number of chairside hours which can reasonably be expected of the average dentist at different ages.

(16) The extent of emigration from Great Britain of doctors and dentists since 1948, and some indication of the countries to which they have gone. The extent to which on the other hand doctors and dentists from other countries (and which countries) have come to Great Britain since the same year. The Commission would welcome some indication of the importance which the Government attaches to these movements.

135. Complete statistical information about migration in general and for doctors and dentists in particular is not available. Figures obtained from the Board of Trade are set out in Table 14 but in studying them it is necessary to bear in mind:

- (a) Doctors and dentists are not separately recorded and the figures are combined figures.
- (b) A migrant is defined in these statistics as a person who intends to change his country of residence for more than a year. Emigrants from the United Kingdom include, therefore: —
 - (i) persons intending a permanent change of residence;
 - (ii) persons going abroad for some years only, e.g. for study or a tour of duty;
- and (iii) persons leaving the United Kingdom after staying for a period of years for study, etc.

A similar description, *mutatis mutandis*, applies to immigrants.

- (c) The Board of Trade's statistics refer to the migration of Commonwealth citizens direct by sea between the United Kingdom and countries outside Europe. An increasing volume of migration of Commonwealth citizens also takes place by air and by the short sea routes between the United Kingdom and the Continent, but comparable information is not available about it.
- (d) Persons coming to the U.K. for undergraduate training as doctors or dentists are counted as immigrant students and not as immigrant doctors or dentists. The same persons later leaving the U.K. after qualification are, however, counted as emigrant doctors or dentists.

136. The Board of Trade comment that, in trying to interpret these statistics, it is necessary to consider the net balance of migrants over the years to and from the United Kingdom. Assuming that information, if available, on air traffic would not produce a contradictory picture, the figures suggest that there have, over the period which they cover, been net inward movements of doctors and dentists from India, Pakistan and South Africa, and net outward movements to the United States, Canada and some other Commonwealth countries. The net loss of doctors and dentists in the earlier years (1951-52) was greater than more recently (1953-56). The Board also say that the rise in the rate of net loss in the first three quarters of 1957 is to be associated mainly with the Suez crisis.

137. Subject to the reservations connected with the interpretation of the Board of Trade's statistics, the figures in Table 13 suggest that there has been no significant change in recent years in the proportionate relationship between emigrant doctors and dentists on the one hand and all emigrants on the other except that the increase in emigration in 1957 (first three-quarters) was less for doctors and dentists than for other classes of emigrants. The bracketted figures indicate the relative annual changes taking 1951 as 100 (for 1957 the yearly figures have been taken as four-thirds those for the first three-quarters).

138. H.M. Government has accepted the recommendation of the Overseas Migration Board that emigration to the Commonwealth be encouraged so long as there is no radical change in the age/sex/occupation composition of emigrants or in the economic position of the home country. It is of course no new thing for some doctors and dentists from Great Britain to take appointments overseas or for some doctors and dentists from Commonwealth countries to take up practice here.

TABLE 13

Emigration direct by sea from the United Kingdom to countries outside Europe
Commonwealth Citizens

		1951	1952	1953	1954	1955	1956	1957 (First nine months)
(a) Doctors and dentists	Number	1,064 (100.0)	1,262 (118.7)	984 (92.5)	972 (91.7)	876 (82.3)	928 (87.3)	762 (95.5)
(b) All Commonwealth citizens	Number	150,774 (100.0)	165,948 (110.1)	144,122 (95.5)	135,712 (90.0)	116,400 (77.0)	129,796 (86.1)	123,038 (108.8)
(a) as proportion of (b).	Per cent	0.71	0.76	0.68	0.72	0.75	0.72	0.62

139. *Willink Report.* In their report the Committee to consider the numbers of Medical Practitioners and appropriate intake of Medical Students (the Willink Committee) speculatively estimated that in the recent past the number of doctors of Great Britain origin making their permanent careers overseas was about 400 per annum, whilst the number of doctors from overseas settling and practising in Great Britain, was about 200 per annum; together these figures gave a net "export" of about 200 per annum. It was the Committee's view that opportunities overseas for doctors from Great Britain and opportunities in Great Britain for doctors from overseas would both decline in the future and in their estimates they allowed for average annual net "exports" of doctors as follows:—

1955-60—160 per annum.
1960-65—110 per annum.
1965-70— 70 per annum.
1970-71— 50 per annum.

General Considerations

140. While statistics for earlier years are not available it is known that the United Kingdom has for many years "exported" doctors and that this has contributed to the international standing of medicine in Britain and has led to other advantages. In so far as the trend has been to less developed countries it has helped to raise the level of medical practice there.

141. The reputation of British medicine and medical training is attracting from abroad both medical students for basic medical training, and large numbers of qualified doctors who are attracted here by the high standard of postgraduate instruction which is available. Furthermore more than 1,000 qualified doctors from abroad are employed in our hospitals, thereby contributing greatly to the alleviation of our medical staffing problem.

142. The interchange of thought and experience represented by these movements is believed to be an important factor in the development of British medicine.

143. The traffic of doctors between India, Pakistan, Malaya and the United Kingdom is in the main a to and fro movement which has served greatly to strengthen the health services of these countries. The excess of emigrants from this country to East and West Africa is due to recruitment of British doctors to the local medical services. It will be counterbalanced in years to come by the return to the United Kingdom of some proportion of these emigrants on completion of service. The excess of emigrants to Australia, Canada, New Zealand and U.S.A. is due to different causes, and has some relation to the general emigration of population to those countries from these islands.

144. The position with regard to dental students and qualified dentists is rather different. A number of foreign dental students and qualified dentists come here for instruction but almost invariably return to their own countries. There is however a small annual addition of foreign dentists who come here, not for instruction, but to settle. There is virtually no export of British dentists overseas.

TABLE 14
Migration of Doctors and Dentists direct by sea between the United Kingdom and countries outside Europe
Commonwealth Citizens

Commonwealth Citizens

Country of last or intended future residence	Immigrants into United Kingdom								Emigrants from United Kingdom								Net Gain or Loss to U.K.	
																	Gain	Loss
	1951	1952	1953	1954	1955	1956	1957 1st 9 months	Total	1951	1952	1953	1954	1955	1956	1957 1st 9 months	Total		
West Africa ...	23	36	26	30	32	20	20	187	58	40	34	80	44	56	40	352	165	
South Africa ...	96	124	112	110	64	90	66	662	50	84	42	58	58	64	44	400	163	
East Africa ...	18	18	20	18	10	8	2	94	63	68	26	30	32	20	18	257		
India and Pakistan	258	250	240	228	206	252	88	1,522	146	158	198	146	134	110	38	930		
Malaya ...	44	36	40	26	22	32	14	214	30	52	30	40	26	22	12	212	2	
Australia ...	123	138	122	172	172	138	102	967	183	232	154	160	118	166	170	1,183		
New Zealand ...	28	50	38	18	20	42	8	204	89	86	88	50	46	58	24	441		
Canada ...	32	46	50	48	44	70	60	350	173	196	176	122	184	146	178	1,175		
British West Indies and Bermuda	11	8	12	32	22	24	20	129	54	66	38	64	42	42	42	348	219	
Other Common- wealth countries	76	100	78	62	54	64	36	470	82	140	102	112	76	86	56	654	184	
United States ...	20	30	68	52	64	46	40	320	122	122	86	96	110	146	138	820	500	
Other Foreign Countries ...	33	14	32	10	16	6	4	115	14	18	10	14	6	12	2	76	39	
Total ...	762	850	838	806	726	792	460	5,234	1,064	1,262	984	972	876	928	762	6,848	2,509	
Net Loss from U.K. ...									302	412	146	166	150	136	302	1,614	1,614	

Note: No information is available for the years before 1951.

(17) Any information which may be available about the earnings of doctors and dentists in other countries in relation to:—

- (a) *the earnings of other professions*
- (b) *the size of the gross national product in these countries.*

145. The information known to exist is given in studies made in several countries, the United States in particular, and in articles in the medical and dental journals. The studies and articles that have been traced are:—

Doctors

United States

- (i) Survey of Current Business for July, 1951, p. 9, "Income of Physicians, 1929-49" by William Winfield, Office of Business Economics, Bureau of Foreign and Domestic Commerce, U.S. Department of Commerce. This compares physicians (a term which apparently covers all kinds of medical practitioners, surgeons as well as those who would be called physicians in this country and general practitioners as well as specialists) with lawyers and dentists.
- (ii) Income from Independent Professional Practice, Friedman and Kuznets, National Bureau of Economic Research, New York, 1945. This is a study of professional incomes in medicine, dentistry, law, public accountancy and consulting engineering—but the data about incomes is more than 20 years old.
- (iii) Trends in Employment in the Service Industries, George J. Stigler. A study by the National Bureau of Economic Research, New York: Princeton University Press, 1956. (Chapter 6 makes a comparison of the professional incomes of physicians, lawyers, college teachers and commissioned officers.)
- (iv) "Medical and Associated Services in the United States" by N. G. Jacoby—*British Medical Journal*, September 8th, 1956.
- (v) "An analytical study of North Carolina general practice 1953/4" published by the Division of Health Affairs, University of North Carolina. This covers all aspects of general practice in North Carolina, including hours of work and pay of practitioners.

Russia

The Medical Press, December 26th, 1956, p. 606.

New Zealand

"A visit to New Zealand" by Ian D. Grant—*British Medical Journal*, Supplement, October 24th, 1953.

Germany

"Die Arztfrage in der deutschen Sozialversicherung": Author—Julius Hadrlich—Berlin, 1955. This book gives information about ranges of medical incomes in Germany, both before the war and since, together with corresponding figures of the general income structure.

Dentists

United States

- (i) Survey of Current Business for July, 1950, contains a brief comparison of the average net and gross incomes of lawyers and dentists (independent and salaried) in 1948 with those in 1949.
- (ii) "Facts about States for the dentist seeking a location, 1957". This was published by the American Dental Association and gives details of the geographical distribution of dentists and their earnings.

Germany

"Social Dentistry in Germany". This is a paper in the *International Dental Journal*, 1956, volume 6, and gives the total earnings of panel dentists.

146. The Australian Newsletter, dated 19th December, 1957, issued by News and Information Bureau, Australia House, contains the following statement under the heading "What professions earned":

"More than 46 per cent of doctors questioned by the Melbourne University Appointments Board earn over £A3,000 a year, but other professions do not do so well.

This was shown by a survey made by the Board which brought in 9,540 answers from professional men. The number of physicists whose earnings reached £A3,000 a year was only 4 per cent.

According to the Board's report, average professional incomes were: medicine, £A3,255; law, £A2,604; dentistry, £A2,490; architecture, £A2,211; engineering, £A2,159; chemistry, £A1,994; accountancy, £A1,832; agricultural science, £A1,814; physics, £A1,814."

It is assumed that these figures represent gross professional incomes in so far as they may relate to earnings in independent practice.

147. Estimates of the gross national product for most countries can be found in the Monthly Bulletin of Statistics published by the United Nations, which also gives the exchange rates. But no publication is known which will give doctors' total earnings to which the gross national product might be related.

148. If the Commission decide to seek further information it is suggested that they might discuss their requirements with the Ministry of Labour with a view to the question being considered whether the Labour Attachés might be asked to endeavour to secure information for the countries which they cover. These countries are listed at the foot of this note. Should information be desired for other foreign countries, the possibility of obtaining it through H.M. representatives might usefully be discussed with the Foreign Office. In the case of the Dominions, enquiry might be made of the High Commissioners.

149. The Commission may wish to consider approaching the International Labour Office.

150. In the case of dentists it is understood that the Federation Dentaire Internationale (35, Devonshire Place, W.1) would be willing to send a small questionnaire on the income of dental practitioners to some of the bigger Dental Associations.

151. The Commission will be aware of the difficulties and dangers of making comparisons of the sort they appear to have in mind in relation to the gross National product, given the great difference between the social systems and standards of the different countries. It is suggested that if they decide to proceed with any inquiry on the lines indicated in paragraphs 148-150 it would be advisable to put it into the hands of a statistician with a view e.g. to arranging that the questions to which Labour Attachés are to be asked to get the answers are strictly defined, that the material collected from each country is on a comparable basis and the results are processed statistically.

Countries covered by Labour Attachés

Attaché's station

Countries covered

Buenos Aires	...	...	...	Argentina, Chile, Paraguay, Uruguay
Vienna	...	...	...	Austria, Yugoslavia
Brussels	...	...	...	Holland, Belgium, Luxembourg
Rio-de-Janeiro	...	...	...	Brazil
Helsinki	...	...	...	Finland, Norway, Iceland
Paris	...	...	...	France
Bonn	...	...	...	Federal Republic of Germany
New Delhi	...	...	...	India, Pakistan, Ceylon
Tehran	...	...	...	Iran
Tel Aviv	...	...	...	Israel
Rome	...	...	...	Italy
Tokyo	...	...	...	Japan
Beirut	...	...	...	Lebanon and Middle Eastern countries
Mexico	...	...	...	Mexico and Central American countries
Singapore	...	...	...	South East Asian countries
Madrid	...	...	...	Spain
Stockholm	...	...	...	Sweden, Denmark
Washington	...	...	...	U.S.A.

(18) The general principles governing the remuneration of persons whose salaries are met out of public funds. Some indication of changes in earnings in these groups (including the nationalised industries) since 1948.

General

152. There are two main categories of persons to be considered in this context. The first category contains employees whose remuneration is wholly, and the second category those whose salaries are partly, financed out of public funds.

153. In the first category a further distinction is to be drawn between on the one hand the Civil Service and the Armed Forces who are directly employed by the State, and on the other the employees of the Health Service who are engaged by authorities which were set up to act as agents of the Minister of Health and Secretary of State for Scotland and which derive the whole of their revenue from the Exchequer.

154. The second category covers, for example, some groups of local authority employees, school teachers, and university teaching staff.

155. The remuneration of the Boards and employees of the nationalised industries does not in general fall to be met out of public funds.

Employees of the State

(a) *Civil Servants*

156. In the factual memorandum supplied to the Commission by the Treasury (dated 31st July, 1957), is a summary of the report of the Royal Commission on the Civil Service (the Priestley Commission) which laid down the principle of "fair comparisons" as the primary principle for fixing civil service pay. Chapter IV of the Priestley Commission's report discusses this principle as well as the degree of importance to be attached to internal relativities in the Civil Service, i.e., to adequate differentials between the pay of different grades in the same hierarchy.

157. The Priestley Commission recommended that, where practicable, the principle of fair comparison should override other considerations affecting pay; in particular it emphasised that if the outside evidence pointed to an adjustment in the pay of a particular grade, which involved some disturbance of internal relativities, then that disturbance must be accepted. The Government will wherever possible apply this principle in future pay negotiations.

158. The Priestley Commission pointed out that the principle of fair comparison had five advantages:—

- (a) It should enable the Government to secure staff of the necessary degree of competence for civil service work.
- (b) It was fair to the taxpayer, who had to foot the bill, since it would ensure that excessive rates were not paid.
- (c) It was fair to the individual civil servant, who would be assured of the appropriate rate of pay for his work.
- (d) It would safeguard the Civil Service from political pressure.
- (e) It would avoid any risk of the Civil Service leading the way in pay revisions.

159. The Priestley Commission realised that the precision with which the principle of fair comparison could be applied would vary a good deal from case to case. Sometimes (as for example in the case of typists) identical work can be found in outside employment; and fair comparison will then give a very clear pointer to the appropriate rate of pay. In other cases it will only be possible to find similar work, and the appropriate rate of pay will be indicated rather less precisely. In still other cases, it will only be possible to find broadly comparable work, and the range within which the appropriate rate of pay is shown to fall might then be fairly wide.

160. The Priestley Commission further recognised that, on occasion, fair comparisons with other comparable employment would have to be adjusted to take account not only of the need for adequate differentials between the different grades in a hierarchy ("vertical" relativities"), but also of "horizontal" relativities. This latter term refers to the need to maintain a proper relationship between grades or classes in different hierarchies whose work is held, or has in the past been held, to be broadly comparable in responsibility or content. Of these two types of relativity, the Priestley Commission regarded the "vertical" as the more important.

161. Figures of the pay of civil servants during the relevant period are set out in Table A appended to the Memorandum of 31st July, 1957, supplied to the Commission by the Treasury. (Reproduced later on in this volume.)

(b) *Armed Forces*

162. The general principles governing the pay of Officers of the Armed Forces are that the pay code should bear comparison with the general prospects offered in other professions, that allowance should be made for the fact that by the nature of his appointment an Officer is put to certain inescapable expenditure, that regard should be had to special factors such as the age of promotion and the system of allowances which operates alongside the pay code, and that proper relationships must be maintained between the various branches of the three Services.

163. Completely revised post-war codes of pay and allowances were introduced for Officers (as well as for Other Ranks) in July, 1946. The rates of pay were generally increased in 1950 and selective improvements were made in 1954 for the middle rank Officers. Further general revisions took place in 1956 and 1958 and the 1958 rates of pay shown in Table 15 are those which will come into operation on 5th April, 1958.

164. Table 15 gives details of pay rates (which are essentially provincial rates because Officers serving in London receive a London allowance). An Officer's pay depends on his rank, the scale of pay of his rank and on the number of years he has served in that rank. Additionally, a married Officer receives a marriage allowance and a non-taxable ration allowance while a single Officer receives rations and accommodation in kind (or cash allowances in their stead).

165. The rates of pay for Medical and Dental Officers were considered by the Waverley Committee, appointed in 1953 by the Minister of Defence "to review the arrangements for providing Medical and Dental Services for the Armed Forces at home and abroad in peace and war; and to make recommendations". The Committee's report was published in two parts in 1956. The 1956 rates of pay for Medical and Dental Officers were assessed in the light of their recommendations except that the small differential in favour of the Medical Officer has in general been maintained.

National Health Service

166. The wage structure of the Health Service is highly complex reflecting both the fact that at its inception the Service took over a large number of employees who were paid by individual hospital authorities at many different rates and the fact that individual units within the Health Service vary greatly in size.

167. The Health Service must pay salaries and wages which will give it the staff it needs. Regard therefore must be had to the remuneration paid by outside employers to staff of the types for which the N.H.S. offers a possible career. It has to be accepted, as in many other services, that in a period of full employment the need of the N.H.S. for certain types of staff cannot always be fully met, though it can and should be adequately met.

168. Section VI and Appendix V of the factual memorandum submitted to the Commission by the Ministry of Health and Department of Health for Scotland set out trends in the pay of National Health Service Classes up to 1957.

Other Bodies

(a) *Local Authorities*

169. An important category in this field is those forms of local government employment which come within the field of specific government grants, e.g. Education, Fire, Police, and Probation services. It has not been the practice in dealing with local authorities for the Government to impose principles which must be complied with in negotiating pay settlements, though in many cases the Government has statutory power to approve or disallow negotiated pay settlements.

170. It is assumed the Royal Commission will obtain direct from the bodies concerned any further information they require in regard to the principles adopted by employers in dealing with salary claims in these various classes of employment.

(b) *Universities*

171. Another major example is the Universities. About 70 per cent of their current expenditure is met from the recurrent grants made to Universities on the recommendation of the University Grants Committee. It is the Universities who employ these staff, not the Government. But as the Universities are, in practice, unable to finance higher salaries without an increase in Government grant, special arrangements have been agreed, under which the University Grants Committee in the light of discussions between representatives of the Universities, as employers, and representatives of the teaching staff, make recommendations to the Chancellor of the Exchequer who decides whether he is prepared to increase the recurrent grant to cover proposed increases.

172. Table 16 shows the changes in University salaries from 1948-57.

(c) *Teachers*

173. Teachers' salaries are reviewed in England and Wales by the two Burnham Committees set up under Section 89 of the 1944 Education Act. Each consists of a local authority panel and a teachers' panel.

174. The main Committee deals with the scales of teachers in primary and secondary schools and county colleges. The Burnham Technical Committee deals with the scales of teachers in technical colleges and schools including commercial and art colleges and schools. In practice the scales for technical and training college teachers have always been built up from those for primary and secondary schools.

175. The Committees review salaries every 3 years, although after the 1951 revision the teachers reserved the right to put forward a further claim within the 3-year period should there be a really steep rise in the cost of living. The Minister of Education cannot partly approve or partly reject any scales of remuneration recommended in the Burnham Report, nor can he approve them subject to modification: the Reports must either be accepted or rejected in their entirety. The main principle guiding the Committee is the need to attract recruits. This means paying to teachers salaries comparable with those of roughly analogous professional grades, i.e. Civil Service grades from Executive Officer to Principal, the administrative, professional and technical grades of local government staffs and the National Health Service general grades. Details of the salaries paid to teachers are shown in Table 17.

176. In Scotland teachers' salaries are broadly comparable in amounts with those in England and Wales, but there are some differences in negotiating machinery. The National Joint Council, which corresponds to the Burnham Committees, makes its recommendations to the Secretary of State for Scotland. There is provision, in the event of a deadlock within the Council, for reference to a tribunal of three arbiters whose deliverance then becomes the recommendation of the Council. The Secretary of State makes statutory regulations prescribing salaries, but before doing so he must take in account the Council's recommendations. He may accept, reject, or modify the recommendations, although in practice he has never departed from them on what seemed to him a major matter.

TABLE 15
Pay of Officers of the Armed Forces—1946-58
General List Officers

	1948 (1946 Code) Per day			1958 Code Per day		
	Navy	Army	Air Force	Navy	Army	Air Force
	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.
Lieut. R.N., Capt., F/Lt. on promotion ...	17 0	23 0	23 0	34 0	42 0	40 0
L/Cdr., Major, S/Ldr. on promotion ...	32 0	35 0	35 0	61 0	63 0	63 0
Comdr., Lt.Col., W/Cdr. on promotion ...	47 6	47 6	47 6	85 0	84 0	84 0
Capt., Col., G/Capt. on promotion ...	65 0	65 0	65 0	106 0	106 0	106 0
R.Adml., M.Gen., A.V.M. on promotion ...	110 0	110 0	110 0	166 0	166 0	166 0
V.Adml., Lt.Gen., A.M. on promotion ...	135 0	135 0	135 0	206 0	206 0	206 0
Adml., General, A.C.M. on promotion ...	160 0	160 0	160 0	246 0	246 0	246 0

Medical Officers

	1948 (1946 Code) Per day s. d.	1958 Code Per day s. d.
Surg. Lieut., Capt., F/Lt. on confirmation ...	28 0	42 0
Surg. L/Cdr., Major, S/Ldr. on promotion ...	43 0	71 0
Surg. Comdr., Lt.Col., W/Cdr. on promotion ...	58 0	91 0
Surg. Capt., Col., G/Capt. on promotion ...	75 0	114 0
Surg. R.Adml., M.Gen., A.V.M. on promotion ...	110 0	166 0
Surg. V.Adml., Lt.Gen., A.M. on promotion ...	135 0	206 0

Notes:

1. *Specialists'* allowance for Medical Officers of Lieutenant Colonel rank or below graded as Specialists was paid at 4s. per day in 1948. In 1950 a higher grade of Senior Specialist was introduced for which an allowance of 8s. per day was paid. The Senior Specialist allowance is now 12s. per day and is payable to all qualified officers up to Colonel rank, and to more Senior Officers if they are filling a Specialist appointment. Broadly similar arrangements exist in the other two Services for allowances for Specialists.

2. *Marriage allowances* which formerly ranged from 12s. 6d. to 20s. a day were increased in 1948 to from 18s. 6d. to 26s. per day, and from April 1958 to from 22s. 6d. to 36s. 6d. per day.

3. *Ration allowance* is reviewed twice yearly against the cost of rations and is currently about £106 a year; it is not taxable.

4. *Permanent Commission Grant* of £1,500 (taxable) is payable to regular Officers on completion of one year's satisfactory service as a Medical Officer; the grant for Dental Officers is £1,250.

5. *Women Medical and Dental Officers* receive the same rates of pay as men.

6. *National Service Officers* are on rates of pay below those of regular officers.

TABLE 16
University Salaries: 1946-57

Post	1946-7(1)	1949	1954	1957	Per cent increase of 1957 over 1949
<i>Clinical Posts</i>					
Professors ...	£1,500-£2,500 (range)	£2,250-£2,750 (range)	£2,500-£2,850 (range)	£2,500-£3,000* (range) *may be increased to £3,250 in certain cases.	11 at bottom and 8 at top of range.
Readers ...	Salaries within the range of the maxima indicated below for lecturers				17 at bottom and 27 at top of range.
Lecturers ...	Salaries ranging from £500-£1,500.	Scales of salary rising from £600 to maxima ranging from £1,500- £2,000.	Scales rising from £700 × £100 to maxima ranging from £1,750 to £2,400.	Scales rising from £900 × £100 to maxima ranging from £1,750- £2,550 (or, in the case of lecturers holding posts of special res- ponsibility-£2,900).	50 at bottom of scale. 17 at bottom and 28 at top of maxima range.
<i>Pre-Clinical Posts</i>					
Professors ...	£1,500-£1,750 (range)	£2,000-£2,500 (range)	£2,250-£2,850 (range)	£2,300-£3,000 (range)	15 at bottom and 17 at top.
Readers ...	Salaries within the range of the maxima indicated below for lecturers				37.5 at bottom and 24 at top of range.
Lecturers ...	£500-£1,000 (range)	Scales rising from £600 to maxima ranging from £1,200-£1,800.	Scales rising from £700 to maxima ranging from £1,450 to £2,050.	Scales rising from £900 × £100 to maxima ranging from £1,650 to £2,250.	50 at bottom of scale. 17 at bottom of maxi- ma range and 25 at top.

TABLE 16 contd.

Post	1946-7 ⁽¹⁾	1949	1954	1957	Per cent increase of 1957 over 1949
<i>Non-Medical Posts</i>					
Professors ...	Basic salaries of £1,450.	Basic salaries of £1,600 with provision for supplementation. (No upper limit prescribed). ⁽²⁾	Basic salaries of £1,900 with provision for supplementation allowing for a range of salaries up to £2,850.	Basic salaries of £2,300: provision for supplementation up to £3,000.	43 in basic salary, 34 at maxima (1957 over 1954).
Readers and Senior Lecturers.	£800-£1,200 (range)	Range of salaries with varying maxima up to £1,600.	Range of salaries with varying maxima up to £1,850.	Range of salaries with varying maxima up to £2,150 or in special cases to £2,250.	34 at maxima.
Lecturers ...	Salaries up to £800.	Scale rising generally from £500-£1,100.	Scale, £650-£1,350	£900 × £50 to £1,350 × £75 to £1,650.	80 at bottom and 50 at top of scale.
Assistant Lecturers ...	£400-£450 (range)	£400-£500 (range)	£550-£650 (range)	£700 × £50-£850	75 at bottom and 70 at top.

⁽¹⁾ Generally recognised scales had not been adopted by the different universities. This was first done in 1949. Hence the percentage comparison with 1949.

⁽²⁾ A sum is separately assessed by the U.G.C. for each institution which may be used in raising the salaries of some of the professors above the standard rate.

TABLE 17
Teachers' Salaries, 1945-56

Teachers' Pay*	(a) 1945 Burnham P. & S. Report		(b) 1948 Burnham P. & S. Report		(c) 1951 Burnham P. & S. Report		(d) 1954 Burnham P. & S. Report		(e) 1956 Burnham P. & S. Report		Percentage Increase of Col. (e) over Col. (a)	
	min.	max.	min.	max.	min.	max.	min.	max.	min.	max.	min.	max.
1. Qualified Assistant: 2 year trained†	300 × 15	525	300 × 15	555	375 × 18	630	450 × 18	725	475 × 25	900	58	71
2. Pass Degree, 4 year trained; no special responsibility allowance ...	345 × 15	585	360 × 15	615	471 × 18	726	546 × 18	821	600 × 25	1,025	74	75
3. Good Honours Degree, 4 year trained; no special responsibility allowance ...	345 × 15	585	375 × 15	645	471 × 18	726	576 × 18	851	650 × 25	1,075	84	83
4. Good Honours Degree, 4 year trained—Scale II post under 1956 Burnham scale (formerly Special Allowance)†	630		745		826		951		1,200		90	
5. Good Honours Degree, 4 year trained—Head of Department Grade C under 1956 Burnham (formerly Special Allowance)†	655		770		876		1,101		1,350		106	
6. Good Honours Degree, 4 year trained—Group XX Deputy Head under 1956 Report (formerly Special Allowance)†	705		820		976		1,251		1,475		109	
7. Headmasters ...	1,380		1,545						2,190		59	

* Provincial Rates: add £36 at minimum and £48 at maximum for each grade and each scale columns (a)-(e) inclusive for London rates.

† A three year training course for all qualified assistant teachers is to be introduced in October, 1960. The current addition to the basic scale for 3 years' training is £18 per annum at maximum and minimum.

‡ The minimum given in each case is that of the appropriate basic scale (i.e. line 3). A teacher may receive a special responsibility allowance at any stage on the scale, but is more probable at a higher rather than a lower stage; hence the only worthwhile percentage comparison is between maxima.

The range of allowances authorised by each of the Burnham Reports (columns (a)-(e)) was as follows:

(a) 1945: £50-£100 per annum (or more if approved by Ministry of Education).

(b) 1948: £50-£150 per annum (or more if approved by Ministry of Education).

(c) 1951: not lower than £40 and with no upper limit specified.

(d) 1954: not lower than £40 and with no upper limit specified.

(e) 1956: not lower than £40 and with no upper limit specified.

- (19) The repercussions (i) in the general field of professional salaries; and (ii) on people whose earnings are met out of public funds which would result from
- (a) any general increase in doctors' or dentists' remuneration;
 - (b) any increase affecting particular types of doctors or dentists; and
 - (c) the permanent linking of medical and dental salaries to the cost of living,
- and the importance attached by the Government to these repercussions.

General

177. Apart from the National Health Service and private practice doctors are employed in the Civil Service, the Armed Forces, Local Government, the Universities and under the Medical Research Council. A reasonable relationship between the pay of doctors in the latter spheres and the salaries of their lay colleagues has therefore to be maintained. At the same time the pay of doctors in these spheres must necessarily be influenced by the remuneration received by doctors outside them, and in practice that means in the National Health Service. Thus an increase in the pay of National Health Service doctors will not only directly affect the pay of doctors in these spheres, but is likely to have widespread indirect repercussions throughout the salaried classes in government and public service. Indeed the effects could be felt throughout the whole field of graduate employment.

178. The supply of people who are capable of acquiring the higher qualifications and skills demanded by the professions, the arts and sciences, senior management and administration is not unlimited. A marked rise in the remuneration of doctors and dentists which had the effect of attracting too large a proportion of the available talent to the medical and dental professions would tend to provoke competitive salary increases by employers of other professions and callings anxious to secure their share of the relatively scarce commodity. The Willink Committee Report made it clear that there is already an excess of candidates for entry to the medical profession in relation to the need for doctors, and recommended a 10 per cent reduction in the output of trained doctors between 1961-1975. There is therefore no case for increased remuneration on recruitment grounds, but rather an indication that the medical profession is, on current standards of remuneration, attracting high quality students with scientific aptitudes who, from the overall national point of view, would be more usefully diverted to a different profession. They are less likely to be so diverted if the pay of the medical profession is markedly above that of comparable professions. It is important therefore to ensure that the level of remuneration of doctors is not raised so that it provokes competitive increases in the level of salaries in broadly comparable fields of employment recruited from people with similar educational and professional qualifications, or distorts the broad initial distribution of that relatively limited number of people over the different professions and callings.

The Civil Service

179. In reviewing the salaries of the Medical Officer class in the Civil Service, the Priestley Commission said:—

“While it is reasonable in our view to have some regard to the standards of remuneration of general practitioners and consultants in the National Health Service, we think that the type of work and conditions of employment of the practising doctors differ materially from those of most civil service medical officers.”

The Priestley Commission also referred specifically to the relevance of the remuneration of consultants to the salary of the highest medical post in the Civil Service.

180. It is therefore evident that any increases in the pay of doctors in the National Health Service would be likely to have repercussions on the pay of those in the Civil Service.

The Armed Forces

181. The pay of Service doctors would have to be reconsidered if there were marked increases in the pay of their civilian counterparts, and this might mean that the pay of Service officers in other branches would also have to be looked at.

Local Government

182. It is assumed that the Royal Commission will seek evidence from local authority sources on this aspect of the matter.

Universities

183. Doctors are employed in the universities on clinical teaching and research. The studies in university medical schools cover both pre-clinical and clinical subjects (the latter involving the treatment of patients). Those engaged on clinical teaching also engage in consultant medical practice in hospitals. In this capacity they are eligible for distinction awards in addition to their teaching salaries. The maximum salary of a professor of medicine who either has no award or a 'C' award, is £3,250; that of a professor holding either an 'A' or 'B' award is £3,000. The amount of the award in each case depends on the number of hours of consultant work per week.

184. This creates a difficult situation. There is strong feeling in university institutions that remuneration should be broadly the same in all faculties for teaching staff of the same grade, and this principle has in general been followed in all cases except medicine. Because of the necessity to pay regard to the remuneration received by doctors in the National Health Service, it has been necessary in the past to establish special scales of pay for medical teaching staff in both clinical and pre-clinical departments. As a result of the increase in academic salaries which took effect on 1st August, 1957 the differential between clinical teaching staff and others was diminished but in part retained. The University Grants Committee considered that some differential was justified by reason of the special responsibilities and obligations of clinical teachers. However, the University Grants Committee and the Committee of Principals and Vice-Chancellors considered the differential between pre-clinical and non-medical salaries to be anomalous, and it did in fact disappear altogether as a result of the August increase, with one entirely minor exception.

185. The Association of University Teachers were in accord with this decision, but the British Medical Association stressed the difficulty of recruiting medically-qualified staff to the pre-clinical departments if salaries compared unfavourably with those obtainable in consultant practice.

186. Because of this situation, the Universities would be particularly affected by any increase in the remuneration of Consultants, the National Health Service grade with which they are most closely linked. Such an increase would lead immediately to pressure for an increase in the pay of clinical professors which would, in its turn, create further pressure for comparable increases for the pre-clinical and non-medical University staff. There might well be considerable resistance in the Universities to any widening of the remaining differentials now in force.

187. For this reason the Universities would also be affected by any change in the system of distinction awards to Consultants.

188. The conditions of employment and the special attraction of the work in Universities are such that direct comparisons between university remuneration and that in other employments are somewhat difficult to make. Nevertheless, an increase in university salaries brought about in the manner just described would give support to a claim for an increase by the administrative grades of the Civil Service and for other salaried occupations in which graduates are predominantly employed.

189. Thus, in brief, an increase in medical remuneration could have considerable repercussions in the Universities, whence they will be liable to spread more widely. Experience at the time of the Danckwerts Award bears out this point.

190. We understand that the Vice-Chancellor's Committee have already been asked for and given written evidence to the Royal Commission on the remuneration of University Teachers as one of the professions with whom Doctors and Dentists are to be compared.

The Medical Research Council

191. The Council is constituted by Royal Charter. The salaries of its employees are paid from Government funds. The Council employs some 180 medical staff.

The salaries of these doctors are necessarily directly affected by the salaries paid in the universities since the work which they do is closely comparable with that of doctors engaged on medical teaching and research in the universities.

Repercussions from changes in dentists' pay

192. The considerations outlined above apply to changes in the pay of National Health Service doctors. The repercussions to be expected from a change in the pay of dentists are of a similar nature, but more restricted in scope. In particular, there would be no appreciable repercussions in the universities. Dentists are employed in the Civil Service, by Local Authorities and in the Armed Services.

Repercussions of the permanent linking of medical and dental salaries to the cost of living

193. It would be very difficult to defend giving automatic protection from the effects of inflation to a particular class of persons remunerated from public funds. These is no more reason why doctors and dentists should have this form of protection than any other persons in public or private employment. While in industry there are some wage agreements which are adjustable with the cost of living these are by no means general. In the Government's view an extension of this system would add greatly to the difficulties of checking inflation, and there is no justification at all for it in occupations in which remuneration is above the average of the community as a whole.

194. The introduction of this system for doctors and dentists in the Health Service would have serious repercussions throughout the public service as all other public employees would naturally claim comparable treatment. To give such treatment would mean guaranteeing to public employees a particular standard of living without regard to the economic condition of the country or to what was happening in other comparable occupations. The effect of granting it would be to aggravate further the inflationary pressure in the economy at the expense of those members of the community who were not similarly guaranteed against the effect of a rise in the cost of living.

(20) The Government's views on the adequacy of the present arrangements for settling the remuneration of doctors and dentists in the National Health Service

195. In 1949 when the general organisation of the Whitley Councils for the Health Services was being worked out, the Health Departments proposed to the medical and dental professions that a Whitley Council should be established for each to provide machinery for consideration of the remuneration and conditions of service of practitioners working in the National Health Service. The proposals envisaged that the medical and dental councils would each appoint committees which would severally deal with:

- (i) the remuneration of practitioners providing general medical and general dental services;
- (ii) the remuneration and conditions of service of practitioners working in the Hospital and Specialist Services;
- (iii) the remuneration and conditions of service of practitioners working for local authorities.

General arrangements for doctors

196. The medical profession agreed to the establishment of a Whitley Council on the lines proposed. The agreed constitution is set out in Appendix C to the Factual Memorandum submitted by the Health Departments.

197. This constitution made provision for the establishment of three Committees. Of these, Committee A would have dealt with the remuneration of medical practitioners providing general medical services; it has, however, never functioned and matters concerning the remuneration of these practitioners have been dealt with, as in the past, by direct discussion between officers of the two Health Departments and representatives of the General Medical Services Committee.

198. The other two Committees provided for by the constitution of the Medical Council have functioned since the Council's establishment in 1950. Most of the practitioners within their scope are paid by salary, though some are primarily engaged in another branch of medicine (commonly general practice) and are paid on the basis of a sessional fee or a fee per case. The Ministers are not in a position to offer comments on the functioning of Committee C since it is concerned only with local authority doctors, for whose pay and conditions of service they are not responsible. Though the Management Side of this Committee includes two representatives of the Health Departments, these representatives attend as observers only. Should the Commission desire to be furnished with an expression of view by the employing authorities of the adequacy of the arrangements provided by Committee C for settling the salaries of local authority doctors, they will doubtless invite the Associations of Local Authorities to supply it.

General arrangements for dentists

199. The dental profession were unwilling to participate in Whitley machinery for dentists employed in the Hospital and Specialist Services or in the general dental services. The Health Departments understand, however, that with the agreement of the British Dental Association, the Staff Side of Committee B of the Medical Whitley Council are now proposing that the constitution of the Medical Council and the scope of Committee B should be amended so that dentists as well as doctors working in the Hospital and Specialist Services will come within the scope of Committee B. So far, matters concerning the remuneration of dentists working in the Hospital and Specialist Services or working in the general dental services, including dentists employed at health centres, have been dealt with in direct discussion between officers of the Departments and representatives of the profession. The decision whether any change in remuneration should be made and, if so, what it should be rests with the Health Departments. As the scale of fees (and in the case of dentists working at health centres, the salaries) for dentists working in the general dental services are embodied in statutory regulations, amending regulations have to be made whenever the remuneration of these dentists is varied; this procedure secures that the changes in remuneration come within the purview of Parliament; for by virtue of Section 75 (2) of the National Health Service Act, 1946, and Section 73 (1) of the National Health Service (Scotland) Act, 1947, the regulations must be laid before Parliament immediately after they are made and if either House within 40 days resolves that the regulations be annulled they cease to have effect. Changes in the remuneration of dentists working in the Hospital and Specialist Services are brought about by a direction given by the Ministers under Regulation 4 of the National Health Service (Remuneration and Conditions of Service) Regulations, 1951, and the corresponding provision in the National Health Service (Scotland) (Remuneration and Conditions of Service) Regulations, 1951.

200. For the remuneration and conditions of service of dental practitioners working for local authorities the dental profession agreed to the establishment of a Dental Whitley Council. On this Council, as with Committee C of the Medical Council, the Ministers' representatives on the Management Side sit merely as observers and should the Commission desire to have information about the effectiveness of these arrangements for dealing with the remuneration of local authority dentists they will doubtless approach the Associations of Local Authorities.

Arbitration

201. Under Section 13 of the National Health Service (Amendment) Act, 1949, any difference or dispute arising with respect to the remuneration or conditions of service of persons working in the National Health Service is within the scope of the Conciliation Act, 1896 and the Industrial Courts Act, 1919. When a dispute occurs, the services of the Minister of Labour are available and the two parties may agree to the dispute being referred to the Industrial Court or, if that is preferred, to some other form of arbitration such as a single arbitrator.

202. In the case of doctors working in the Hospital and Specialist Services (i.e., those within the ambit of Committee B of the Medical Whitley Council) assurances were given in July, 1949, on behalf of the Government that:

- (1) no changes would be made in the Terms and Conditions of Service without discussion in the appropriate part of the Whitley machinery;
- (2) remuneration was regarded as a subject suitable for arbitration;
- (3) save in exceptional circumstances and if the conciliation machinery of Whitley had been exhausted, issues of remuneration remaining in dispute would go either to arbitration or for enquiry and report by a committee.

The Government's views about arbitration in relation to medical and dental remuneration are set out more fully in the answer to question 22.

Working of the arrangements in relation to practitioners

203. Summarised, the arrangements for practitioners with which the Health Departments are directly concerned are:—

- (a) Committee B of the Medical Whitley Council (for doctors working in the Hospital and Specialist Services);
- (b) the direct discussions which take place on the salaries of dentists working in the Hospital and Specialist Services;
- (c) the direct discussions which take place on the remuneration of medical practitioners providing general medical services;
- (d) the direct discussions which take place on the fees of dentists providing general dental services (and on the salaries of dentists providing such services at Health Centres).

204. Since Committee B was formed in 1950, it has met on 32 occasions. In conjunction with the work of the main Committee, sub-committees have been set up to consider particular matters. 38 agreements have been reached and embodied in circulars issued to hospital authorities by the Committee. Other agreements have been reached and given effect to by circulars issued to hospital authorities by the Health Departments.

205. Three agreements were reached after disputes between the two Sides had been referred to the Industrial Court. These agreements related to:—

- (1) The salary scales for senior administrative medical officers and their deputies and for regional psychiatrists (Industrial Court Award No. 2322—National Health Service).
- (2) The remuneration of Medical Superintendents in England and Wales (Industrial Court Award No. 2357—National Health Service).
- (3) The salary scales for Senior Hospital Medical Officers (Industrial Court Award No. 2606—National Health Service).

206. The most important agreement reached by Committee B was that concluded in 1954 for the introduction of new increased salary rates for all grades from house officer up to and including consultant. Though for a time no progress was made in the discussions between the two Sides on the salary claim itself, a basis of agreement emerged from informal discussions which took place outside Committee B and was adopted by the Committee.

207. The arrangements outlined in the preceding paragraphs follow the line of widely established machinery for joint discussion on remuneration and conditions of service. Committee B has a considerable number of agreements to its credit and in general can be said to have functioned satisfactorily. Like many Whitley arrangements in the National Health Service however it suffers from the difficulty that the representatives of the Government, which has to provide the money, are in a minority on a Management Side composed largely of representatives of the hospital authorities anxious to do their best for the medical staff whose employers they are. This aspect of the general arrangements in the National Health Service is under review by the Government.

208. For dentists working in the Hospital and Specialist Services, it is the usual practice of the British Dental Association, acting for the profession, whenever an increase in the pay of hospital medical staff is agreed by Committee B of the Medical Whitley Council to seek a similar increase for the corresponding dental staff—in view of the recommendations of the Dental Spens Committee that dental specialists should be remunerated within the same range as medical specialists. The Ministers, while prepared to consider such claims on merits, have not felt able to accept the view that dental staff should automatically receive increases agreed by Committee B for medical staff, but so far the discussions have resulted in corresponding increases being given. The Ministers consider that it would make for convenience if questions relating to the salaries of hospital dentists were dealt with by a Whitley Council.

209. As stated in paragraph 197, the remuneration of doctors providing general medical services has been the subject of direct negotiation. This does not in itself create any problems. The difficulties which have arisen in relation to the remuneration of these practitioners have been the result not of any inadequacy in the negotiating arrangements but of a fundamental disagreement on the basis of the remuneration—a disagreement of a nature that no change in the negotiating machinery could hope to resolve.

210. By contrast, it was possible to reach agreement in direct negotiations with the Dental Profession in 1955 on the basis of remuneration for dentists providing general dental services and in 1957 on the fees to be paid for the different items of service.

Scottish Advisory Committee of the Whitley Councils

211. The main Constitution of the Whitley Councils for the Health Services provides that in certain circumstances a matter may be referred for advice to the Scottish Advisory Committee of the Councils. Such references are confined to cases where some special Scottish condition emerges *prima facie*. The Scottish Advisory Committee then sets up an appropriate Sub-Committee to deal with the particular matter and reports back to the main Council or Committee on which the question arose. It is constitutionally open to the main Whitley Council or Committee to reject the conclusions reached on the Scottish Advisory Committee, but in practice this does not occur.

Summary

212. The arrangements for settling the remuneration of doctors and dentists in the National Health Service have not proved inadequate in themselves. There have been disagreements between the parties but disagreements are bound to arise from time to time in any process of negotiation. The fundamental disagreement which has arisen between the Government and the medical profession on a major premise is not the result of inadequate negotiating machinery. Special considerations arise in relation to the machinery for settling disputes; these are dealt with in the answer to question 22.

(21) Information about the arrangements for keeping under review the salaries of senior Civil Servants which have been introduced following the Report of the Royal Commission on the Civil Service; and views on whether some arrangements of this kind would be appropriate for advising on the salaries of doctors and dentists.

213. The arrangements for keeping under review the salaries of senior Civil Servants are set out in the Treasury Memorandum which begins on page 769. As that Memorandum explains, the considerations which led the Royal Commission on the Civil Service to recommend the setting up of the Advisory Committee on the Higher Civil Service are described in full in paragraphs 377-391 of their Report. The Commission may wish to refer to this passage.

214. The second part of question 21 can be most conveniently answered in conjunction with the answer to question 22.

(22) Information about the various systems of arbitration used in settling disagreements about wages and salaries. Views on how far any of these methods might be appropriate for the settlement of disputes about the remuneration of doctors and dentists.

I. Arrangements for arbitration generally

215. The Industrial Court, set up under the Industrial Courts Act of 1919, and the Industrial Disputes Tribunal, governed by the Industrial Disputes Order of 1951, are the two principal bodies which arbitrate on disputes about wages in the field of private and public enterprise.

216. A number of industries and services use their own arbitration machinery, designed to meet their particular needs. Typical examples are given from the field of public enterprise. The Ministry of Labour's Industrial Relations Handbook contains further material.

The Industrial Court

217. When a trade dispute arises, and the two parties agree to arbitration under the Industrial Courts Act, it is referred to the Minister of Labour who can, with both parties' consent, refer it to the Industrial Court or to ad hoc arbitration before one or more persons appointed by him, or refer it to a special Board of Arbitration consisting of nominees from each side plus an independent Chairman. Section 2 (4) of the 1919 Act provides that the Minister is not to refer a trade dispute in a particular industry to any of these methods of arbitration until the industry's own machinery has been exhausted. Arbitration under the Industrial Courts Act is not available to persons in the armed forces of the Crown but is available to workmen employed by or under the Crown.

218. Arbitration awards under the Industrial Courts Act are not legally binding but since they are the result of joint application by the parties they are almost invariably accepted.

219. The Industrial Court can arbitrate on any trade dispute within the meaning of the Industrial Courts Act, 1919, only if both sides give their consent. The Court is a standing, independent tribunal consisting of persons appointed by the Minister of Labour and National Service of whom some are independent persons, some are persons representing employers and some persons representing workpeople. The President of the Court is usually a barrister of high standing who has a wide knowledge and understanding of industrial relations. He is entirely independent of either side of industry. The present holder of this office is Sir John Forster, who has been President since 1st January, 1946. Usually the Court consists of the President sitting with two whole-time members, one representing employers and the other representing workpeople. The Court has the power to call in the aid of assessors although this is very seldom exercised.

220. The National Health Service (Amendment) Act, 1949, provided that any difference or dispute arising in respect of the remuneration or conditions of service of persons employed or engaged in the provision of services under the National Health Service Acts shall be deemed to be a dispute within the meaning of the Industrial Courts Act, 1919.

The Industrial Disputes Tribunal

221. Reference to the Industrial Disputes Tribunal is governed by the Industrial Disputes Order of 1951 (S.I. No. 1376). The type of dispute covered is limited to those which concern the terms of employment or conditions of labour of members of a trade union (but not, as the law stands at present, members of a professional association). Either side can compel the other to go to arbitration before the Tribunal, provided that all practicable means of reaching a settlement through the existing machinery of negotiation or arbitration in the industry, or section of industry or undertaking, have been exhausted. The decision of the Tribunal is binding; any award becomes an implied term of the contract between the employer and workers to whom the award applies. The Industrial Disputes Order is not binding on the Crown.

222. For any particular case the Tribunal consists of five members, three of whom are drawn from a panel of independent members appointed by the Minister and one each from panels of employers' and workers' representatives appointed by the Minister after consultation with the British Employers' Confederation and the Trades Union Congress respectively. One of the independent members acts as standing Chairman of the Tribunal and at present this office is held by Lord Terrington. The field of appointment of the independent members is in general the Universities and the legal profession.

The Civil Service Arbitration Tribunal

223. This Tribunal was set up in its present form in 1936. It deals with questions affecting the emoluments, hours of work and leave of non-industrial Civil Servants on which the Government and representatives of recognised Staff Associations have failed to reach agreement. It consists of three members; an independent Chairman appointed by the Minister of Labour, one member from a panel appointed by the Minister as representing the Chancellor of the Exchequer and one member from a similarly appointed panel representing the Staff Side of the National Whitley Council.

224. Either the Staff Side or the Official Side can apply for a dispute to be referred to the Civil Service Arbitration Tribunal, but generally speaking this right to go to arbitration only applies to those whose salary scale does not at the minimum and maximum exceed certain limits or whose fixed rate does not exceed a certain maximum, the limits in both cases being broadly related to the scale of the Principal, the minimum and maximum of which are at present £1,450 and £2,050. The Royal Commission on the Civil Service upheld the provision that the right of "compulsory" arbitration should be restricted. It said "Successive Governments have always taken the view that posts at managerial level should not be subject to compulsory arbitration. Senior civil servants occupy a delicate position as advisers to Ministers on all questions of Government policy, and it would not be right or appropriate that persons who occupy this position and are engaged on these duties should have the right to take the Government to compulsory arbitration."

225. *The Police Service* has a special arrangement for arbitration in the form of an Arbitration Tribunal of three arbitrators appointed by the Prime Minister. Either the employers' or the employees' side of the Police Council for Great Britain, which is the negotiating body for police pay, have the right to refer a dispute on police pay to the arbitrators, whose decision, like those of the Council apply, subject to the formal approval of the Home Secretary, to all members of the police without any upper limit of salary. The only exemption is the Commissioner of Police in the Metropolitan Police (present salary £5,500 per annum).

The Railway Staff National Tribunal

226. This Tribunal functions to decide issues as to standard salaries, wages, hours and other standard conditions of service which have not been settled by the Railway Staff National Council. Submission to the Tribunal may be at the instance of one side but the issues it deals with must have been agreed or decided in a prescribed manner to be "issues of major importance". The Tribunal can deal with issues affecting "conciliation grades" and salaried staff, exclusive of salaried staff above the "special class" categories. It does not deal with railway shopmen, employees in electricity generating stations or police. In general effect these arrangements leave salaried staff on more than £956 per annum outside the scope of the Tribunal and there are no arbitration arrangements for such staff.

227. The Tribunal consists of only three members, one selected by the British Transport Commission, one by the Railway Trade Unions, and the Chairman appointed either by agreement between the Railway Staff Conference and the Railway Trades Unions or by the Minister of Labour after consultation with the parties. The present Chairman is Sir John Forster, who was appointed by the Minister of Labour on the agreed nominations of the two sides. A fresh selection of each of the members, except the Chairman, is made for each case coming before the Tribunal. The members are selected from two previously nominated

panels consisting of persons not connected with the railways. Each Trade Union party to an issue may if it desires nominate one Assessor, and the British Transport Commission may nominate an equivalent number, to assist the Tribunal.

228. Issues involving interpretation of a National Agreement, or certain other issues may be referred for decision to the Chairman of the Tribunal acting by himself provided they have not been settled at the appropriate previous stage of the machinery.

229. Decisions of the whole Tribunal are not binding, but decisions on issues referred to the Chairman are.

Nationalised Industries Generally

230. Most of the Nationalised Industries have arrangements for the settlement of disputes which include provisions for disputes about wages and conditions of service to be settled by arbitration either by one of the standing Arbitration Tribunals or by specially constituted arbitration tribunals on the lines of those described above. In these agreements each side binds itself not to withhold consent to go to arbitration if the other side requests it.

231. In the coal industry, managerial grades with a salary range above £2,250 are not covered by negotiating agreements and there are no arbitration arrangements for such grades. The National Coal Board think it is inappropriate that the salaries of these senior officials should be settled by collective bargaining and the question of arbitration arrangements does not therefore arise. In the Electricity Supply and Gas Industries agreements to refer disputes to arbitration cover all grades but in Transport, Civil Air Transport and Road Haulage there are no agreements to refer claims in respect of administrative and top managerial grades to arbitration nor are such arrangements made in practice. The agreement for non-manual workers employed by the Atomic Energy Authority has a clause precluding reference to arbitration on claims in respect of grades whose salary is above £1,700 per year without the consent of both parties concerned in the claim. In the absence of such consent there are no other arrangements for these grades.

Industry Generally

232. It is understood that in industry generally outside the "public sector" salaries and conditions of service of managerial grades are not subject to collective bargaining, and the question of arbitration does not therefore arise.

Local Government Service

233. The negotiating machinery applies to all grades. On the administrative side there is in general no provision for arbitration but in the case of even the most senior officers (some on salaries in excess of £2,500 per annum) there is no obstacle to access to the Industrial Disputes Tribunal. Medical and Dental officers come within the scope of the Whitley Councils for the Health Services, medical officers being covered by Committee C of the Medical Whitley Council and dental officers being covered by the Dental Whitley Council (Local Authorities). Disputes on the remuneration of doctors and dentists can be referred to the Industrial Court and references have in fact been made on a number of occasions.

National Health Service

234. By virtue of the provisions relating to disputes contained in the National Health Service (Amendment) Act, 1949, to which reference has already been made in paragraph 220, arrangements could be made for disputes to be referred to a Board of Arbitration set up by the Minister of Labour and National Service under section 2 (2) (c) of the Industrial Courts Act, 1919, and it was hoped to set up a National Health Service Arbitration Tribunal, which would specialise in National Health Service questions of wages and conditions, as the Civil Service Arbitration Tribunal specialises in civil service questions.

235. The two sides of the General Whitley Council, after negotiations over the period 1949-1953 were unable to conclude an arbitration agreement. The Management Side maintained, first, that as the whole basis of arbitration in the National

Health Service rested on the National Health Service (Amendment) Act, 1949, which brought disputes in the Service within the scope of the Industrial Courts Act, 1919, this made reference to arbitration subject to the consent of both parties in accordance with Section 4 (2) of the 1919 Act—and that, second, because of their overriding responsibility for the National Health Service the Health Ministers should be able to intervene in exceptional circumstances to prevent a particular dispute from being referred to arbitration. The Staff Side contended that the agreement should provide a right to compulsory arbitration and that the Ministers should only be able to intervene at the stage when their approval was sought to the implementation of the award. These differences could not be resolved.

II. Extent to which the preceding methods would be appropriate for settling disputes about the remuneration of Doctors and Dentists in the National Health Service.

236. The description in Part I of the arbitration arrangements in this country brings out:

- (a) that for large sections of the community, the normal system (excluding references to the Industrial Disputes Tribunal) involves the consent of both parties as a condition of arbitration;
- (b) that in a number of occupations arbitration is not considered suitable for the more senior and highly paid categories.

237. Arbitration has in fact played little part since the setting up of the National Health Service in determining the pay of doctors and dentists. The reference to Mr. Justice Dankwerts in 1952, made with the consent of both parties, was ad hoc on a special issue. The Industrial Court is indeed empowered to hear such references if they are made with the consent of both parties, and they have made awards on the pay of Administrative Medical Officers of Regional Boards, on Medical Superintendents' pay and on the pay of S.H.M.Os. They have also heard a number of references from other categories in the National Health Service. No references, however, have been made to this Court in regard to the general body of doctors and dentists.

238. The Government for their part consider that it would be inappropriate to settle the remuneration of doctors and dentists in the National Health Service under the existing arbitration machinery. They take this view for a number of reasons.

239. First, a claim like the present claim inevitably involves the whole of a large profession and such questions as the proper economic and social status of that profession in the community as a whole. It seems hardly suitable to refer such issues to bodies concerned normally with references far less complicated and far narrower in their implications.

240. Secondly, the normal arbitration tribunal has, of necessity, to adopt an ad hoc approach to the problems that come before it, and it arrives at its decisions on the basis of material provided by the two parties to the dispute. It is submitted that there would be considerable advantage if the remuneration for managerial and professional posts was considered:

- (a) by a body whose members familiarised themselves with the special problems involved in such references and who brought to bear the experience gained over a period of years;
- (b) by persons who, of their own knowledge, were aware of the remuneration and standards in relevant private and public employment.

241. Third, and most important of all, the normal type of arbitration involves the consent of both parties with the implication that the award will be accepted by both sides. As Part I of this section shows, a number of important employments make it a fundamental feature of their system that their managerial and more highly paid employees should be excluded from such references. The Government have made plain in their practice of many years' standing that they cannot allow remuneration in the higher levels of the Public Services to be determined by arbitration. In their view the same considerations apply to doctors and dentists

in the National Health Service. Not only are the salaries at a level which other employers consider should not be determined in arbitration, but it is an undoubted fact that salaries in this profession have a considerable influence on salaries in other professions recruited from graduates. The Government cannot lightly agree to the determination of salaries in this field by ad hoc references to arbitration.

242. The problem therefore seems to be:

- (a) on the one hand to avoid a procedure under which disputes can be taken compulsorily to arbitration, a right which for the reasons given above, could only be given subject to conditions which would make it meaningless; and
- (b) on the other hand to provide machinery which secures consideration of any disputes in this field by an independent and authoritative body.

243. The Royal Commission on the Civil Service, whilst accepting that arbitration was unsuitable in the case of the higher Civil Service, recommended the appointment of a standing advisory committee to exercise a general oversight over remuneration at these levels in the Service. This recommendation was accepted by the Government. It is submitted that the appointment of a body similar to the Coleraine Committee to advise the Government on the remuneration of doctors and dentists might be justified by similar consideration.

Observations on the Statistical Evidence presented by the British Medical Association

244. The Spens Reports referred to two factors which they suggested should be taken into account when deciding on the post-war equivalents of the salaries which they considered would have been appropriate in 1939—the change in the value of money, and the increases that had taken place in incomes in other professions. If applied literally these two factors would, in practice, almost invariably produce different results. Over the period April, 1951, to October, 1957, the general level of prices, as measured by the price index of all consumer goods given in the National Income Blue Books, rose by 29 per cent. The British Medical Association rest their case mainly on this figure and not on the increase in incomes in other professions over the same period, which has been very much less (see paragraph 248, below).

245. In the evidence which the British Medical Association presented to Mr. Justice Danckwerts, Professor R. G. D. Allen estimated a price index appropriate to the middle class, including doctors. Over the period 1938 to 1951, his middle class price index rose by more than the Blue Book price index covering all consumers. Professor Allen has not carried his estimate forward beyond 1951. His method is to compare the Ministry of Labour's index of retail prices, which covers working class households and small salary earners, with the price index covering all consumers and, after allowing for differences in weighting and in the methods of pricing, to calculate the middle class index by subtraction. The Ministry of Labour's retail price index rose by 37 per cent between April, 1951, and January, 1958 (the latest date for which, at the time of writing, the index is available). Over the same period the price index of all consumer goods rose by about 29 per cent according to provisional estimates; after removing as far as possible the differences in the method of calculation, the latter shows an increase of about 30 per cent. The Ministry of Labour's index covers all households of which the head is a manual worker or a salary earner getting less than £1,000 p.a., and these comprise 90 per cent of all households. It follows that an index of prices appropriate to the professional and managerial classes would show only a small rise, perhaps of about 10 per cent, in this period; at any rate it would show a much smaller rise than the general index of consumer prices.⁽¹⁾

246. The British Medical Association switch their argument from one index to the other, choosing whichever gives the higher result in each period. Since the Association, in their evidence before Mr. Justice Danckwerts, used an index which Professor Allen had calculated for the middle class, and this evidence was

⁽¹⁾ The latter also includes pensioner households which are excluded from the Ministry of Labour's index; but this does not affect the conclusion.

taken into account in the Danckwerts Award, they ought to use the same index for the period since 1951. The difference between the two indices is, in fact, much greater in the period since 1951 than it was in the period 1938-51. Hence an index appropriate to the middle class would show a smaller rise from 1938 to date than the general index of consumer prices.

247. Another method used by Professor Allen is to estimate equivalent points in the distribution of incomes. According to the results presented in Appendix IX of the British Medical Association's memorandum, this method shows an increase of between 13½ per cent and 16½ per cent (depending on the particular points chosen) between 1949-50 and 1954-55, when the general index of consumer prices rose by about 23 per cent. Incidentally, Professor Allen allows, in this calculation, for the increase of 4 per cent in the number of income earners since April, 1951. He did not allow for the increase in the number of income earners since 1938 in a very similar calculation which was included in the British Medical Association's evidence to Danckwerts. The Association do not, however, now admit that they were asking for too much at that time.

248. Appendix VII of the British Medical Association's memorandum, drawing on estimates presented by Professor Allen in the Sub-Appendix to this Appendix, states that the incomes of the self-employed professions (excluding general practitioners) have risen by 25 per cent between April, 1951, and April, 1956 (paragraph 32). This figure refers to *total* incomes, not to average incomes, and is based on Central Statistical Office estimates which were revised when the White Paper, *Preliminary Estimates of National Income and Expenditure 1951 to 1956* (Cmd. 123, April, 1957), was published. The revised estimates of total income of the self-employed professions, after deducting the Association's estimates for general practitioners, are £185 million in 1951 and £209 million in 1956, an increase of 13 per cent. Since the number of incomes included in this group (excluding general practitioners) has risen in the same period by about 5 per cent the average income per head of all self-employed professional people other than general practitioners has risen by only about 8 per cent since 1951, or much less than Professor Allen's estimate of 25 per cent which refers to the same group. This group covers all self-employed professional people other than general practitioners and includes authors, actors, artists, etc., as well as barristers, solicitors, architects, surveyors and accountants.

249. Appendix VII of the Association's memorandum also refers to increases since April, 1951, in the salaries of civil servants and particularly to those of the Administrative class which the Association describe as "an obviously fair case" for comparison. Since these increases were intended to make up ground which had been lost over a long period of years, present-day salaries ought to be compared with pre-war salaries rather than with salaries in 1951. It will be seen from Table 18 that the salaries of most of the Administrative class of the Civil Service are, even today, less than 100 per cent higher than they were in 1939, whereas the doctors had already, in 1951, been granted increases of 100 per cent over the salaries which the Spens Committee had recommended as appropriate in 1939. The salaries recommended by the Spens Committee were, in turn, substantially higher than the actual salaries which doctors received in 1939; the Committee recommended increases of 50 per cent for the lowest salaries, tapered down to no increase for those earning over £2,000 in 1939. (Note 1. to recommendation (1) of the Spens Report on General Practitioners' Remuneration.) Since 1951, therefore, the salaries of doctors in the junior grades have been 200 per cent higher, while those of doctors in the most senior posts have been 100 per cent higher, than their actual pre-war salaries.

250. The British Medical Association have chosen a very roundabout method of making comparisons between the present-day salaries of doctors and those of members of other professions. They take the salaries which the Spens Committee recommended as appropriate to 1939 as a starting point; they assume that changes in prices and salaries between 1939 and April, 1951, were correctly taken into account by the Danckwerts award, made in March, 1952, and that the appropriate relationship had, by then, been established between salaries in the medical and other professions; and their evidence is therefore mainly concerned with trying to decide how much increase is required in doctors' salaries to take account of the changes

that have taken place since April, 1951, in prices and other incomes. Their method thus involves three distinct stages; and, since assumptions and approximations have to be made at each stage, the final result is unlikely to be very reliable. In particular, the assumption that, by 1951, the appropriate relationship had been established between salaries in the medical and other professions is open to question. Changes that have taken place since 1951 in salaries in other professions e.g. of University lecturers, teachers and Civil Servants, have probably led to more normal relationships generally. The direct comparison between salaries paid at the present time in different professions (mentioned in the terms of reference) is clearly a much simpler method; it involves fewer assumptions and approximations; it avoids the need to consider the changes that have occurred in different periods of the past; and it seems more likely, therefore, to produce reliable and generally acceptable results.

**Addendum to Observations on the Statistical Evidence presented by the
British Medical Association**

251. It is possible to calculate a rough price index appropriate to middle class households for the period since April, 1951, using the same method that Professor Allen used for the period 1938 to April, 1951. The Ministry of Labour's Index of Retail Prices rose by 36.3 per cent between April, 1951, and February, 1958 (the latest date for which the index is available). Over the same period, the consumer price index rose by 27.9 per cent⁽¹⁾. To bring the two indices on to a comparable basis, the latter was recalculated using 1951 weights (for headings of expenditure shown in the National Income Blue Books) for the period up to January, 1956, and 1953 weights thereafter; differences in the methods used in measuring the price changes of certain items (rail travel, fruit and vegetables) were also eliminated. The resulting consumer price index shows an increase of 29.0 per cent between April, 1951, and February, 1958.

252. Prior to January, 1956, the Ministry of Labour's retail price index covered about 65 per cent of consumers' expenditure⁽²⁾. The Ministry of Labour's new index, introduced in January, 1956, assuming that it applies to pensioner households as well as to the households whose expenditure formed the basis of the weights, covers about 87 per cent of consumers' expenditure⁽³⁾. Recent estimates by Professor Allen⁽⁴⁾ show that the cost of living of pensioner households has risen more than the Retail Price Index in recent years. If this is taken into account, the price index appropriate to middle class households would be reduced.

253. A rough index appropriate to all households other than those assumed to be covered by the Ministry of Labour's index can be calculated, since the two indices, combined in the proportions stated, should agree with the price index of all consumers' expenditure. Any errors will be magnified in the result which is unlikely, therefore, to be very accurate. Over the period April, 1951, to February, 1958, the middle class price index, so calculated, shows a rise of 11 per cent.

254. The consumer price index covers, even under a single heading of expenditure, many different kinds of goods sold through all the different types of shops. This calculation therefore takes account of the fact that the kinds of goods bought by middle class households and the outlets through which they are bought are often different from those used in compiling the Ministry of Labour's Retail Price Index.

⁽¹⁾ Strictly the consumer price index is available for calendar years only. The figure for February 1958 has been obtained by assuming the same percentage change in the index since 1957 (average) as is shown by the Ministry of Labour's index over this period. The figure for April 1951 is calculated in a similar way.

⁽²⁾ This figure is obtained by expressing as a proportion of total consumers' expenditure an estimate of working class income net of direct taxes. This consists of wages, a rough estimate of the salaries of those who were eligible for national insurance under the old scheme, the pay of other ranks of H.M. Forces and the bulk of pensions and other government transfers. The property income of households covered by the index is assumed to be offset by savings.

⁽³⁾ Obtained by combining the relative numbers of income tax units under and above £1,000 a year with the average expenditures shown by the Ministry of Labour's Household Expenditure Survey in 1953.

⁽⁴⁾ "Movements in Retail Prices since 1953", *Economica*, February, 1958.

TABLE 18

Civil Service: Salaries in the Administrative Class

	Step in salary scale	Salaries (£ per annum) at:						Percentage increase between 1.4.39 and:								
		1.4.39	1.1.46	1.1.47	1.1.48	1950*	1.1.53	1.4.56	1.7.57	1.1.46	1.1.47	1.1.48	1950*	1.1.53	1.4.56	1.7.57
Permanent Secretary	—	3,000	3,500	3,500	3,500	4,500	4,500	6,000	6,000	16.7	16.7	16.7	50.0	50.0	100.0	100.0
	—	2,200	2,500	2,500	2,500	3,250	3,250	4,250	4,250	13.6	13.6	13.6	47.7	47.7	93.2	93.2
Deputy Secretary	—	1,700	2,000	2,000	2,000	2,500	2,600	3,400	3,400	17.6	17.6	17.6	47.1	52.9	100.0	100.0
	Step 1	1,150	1,200	1,320	1,320	1,500	1,700	2,100	2,100	4.3	14.8	14.8	30.4	47.8	82.6	82.6
	2	1,200	1,250	1,370	1,370	1,575	1,775	2,200	2,200	4.2	14.2	14.2	31.2	47.9	83.3	83.3
	3	1,250	1,300	1,420	1,420	1,650	1,850	2,300	2,300	4.0	13.6	13.6	32.0	48.0	84.0	84.0
	4	1,300	1,350	1,470	1,470	1,725	1,925	2,400	2,400	3.8	13.1	13.1	32.7	48.1	84.6	84.6
	5	1,350	1,400	1,520	1,520	1,800	2,000	2,500	2,500	3.7	12.6	12.6	33.3	48.1	85.2	85.2
	6	1,400	1,450	1,570	1,570	1,900	2,100	2,600	2,600	3.6	12.1	12.1	35.7	50.0	85.7	85.7
	7	1,450	1,500	1,620	1,620	2,000	2,200	2,700	2,700	3.4	11.7	11.7	37.9	51.7	86.2	86.2
	8	1,500	1,550	1,670	1,670	2,000	2,200	2,700	2,700	3.3	11.3	11.3	33.3	46.7	80.0	80.0
	9	1,500	1,600	1,700	1,700	2,000	2,200	2,700	2,700	6.7	13.3	13.3	33.3	46.7	80.0	80.0
Principal ...	10	1,500	1,650	1,700	1,700	2,000	2,200	2,700	2,700	10.0	13.3	13.3	33.3	46.7	80.0	80.0
	Maximum	1,500	1,700	1,700	1,700	2,000	2,200	2,700	2,700	13.3	13.3	13.3	33.3	46.7	80.0	80.0
	Step 1	800	800	900	950	1,000	1,150	1,375	1,450	—	12.5	18.8	25.0	43.8	71.9	81.3
	2	830	830	930	980	1,040	1,190	1,425	1,500	—	12.0	18.1	25.3	43.4	71.7	80.7
	3	860	860	960	1,010	1,080	1,240	1,475	1,550	—	11.6	17.4	25.6	44.2	71.5	80.2
	4	890	890	990	1,040	1,120	1,290	1,525	1,600	—	11.2	16.9	25.8	44.9	71.3	79.8
	5	920	920	1,020	1,070	1,160	1,340	1,575	1,655	—	10.9	16.3	26.1	45.7	71.2	79.9
	6	950	950	1,050	1,100	1,200	1,390	1,650	1,730	—	10.5	15.8	26.3	46.3	73.7	82.1
	7	980	980	1,080	1,135	1,250	1,440	1,725	1,810	—	10.2	15.8	27.6	46.9	76.0	84.7
	8	1,010	1,010	1,115	1,170	1,300	1,490	1,800	1,890	—	10.4	15.8	28.7	47.5	78.2	87.1
Principal ...	9	1,040	1,040	1,150	1,205	1,350	1,540	1,875	1,970	—	10.6	15.9	29.8	48.1	80.3	89.4
	10	1,070	1,070	1,185	1,240	1,375	1,570	1,950	2,050	—	10.7	15.9	28.5	46.7	81.8	91.6
	Maximum	1,100	1,100	1,220	1,280	1,375	1,570	1,990	2,050	—	10.9	13.6	25.0	42.7	77.3	86.4

TABLE 18—contd.

	Step in salary scale	Salaries (£ per annum) at:						Percentage increase between 1.4.39 and:								
		1.4.39	1.1.46	1.1.47	1.1.48	1950*	1.1.53	1.4.56	1.7.57	1.1.46	1.1.47	1.1.48	1950*	1.1.53	1.4.56	1.7.57
Assistant Principal	Step 1	275	275	360	400	400	470	605	635	—	30.9	45.5	45.5	70.9	120.0	130.9
	2	300	300	385	425	425	500	635	665	—	28.3	41.7	41.7	66.7	111.7	121.7
	3	325	325	410	450	450	530	665	700	—	26.2	38.5	38.5	63.1	104.6	115.4
	4	355	355	440	480	480	560	695	730	—	23.9	35.2	35.2	57.7	95.8	105.6
	5	385	385	470	510	510	590	725	760	—	22.1	32.5	32.5	53.2	88.3	97.4
	6	415	415	500	540	540	620	755	795	—	20.5	30.1	30.1	49.4	81.9	91.6
	7	445	445	530	570	570	650	785	825	—	19.1	28.1	28.1	46.1	76.4	85.4
	8	475	475	560	600	600	680	815	855	—	17.9	26.3	26.3	43.2	71.6	80.0
	9	505	505	590	630	630	715	845	885	—	16.8	24.8	24.8	41.6	67.3	75.2
	10	535	535	620	660	660	750	875	920	—	15.9	23.4	23.4	40.2	63.6	72.0
	11	565	565	650	690	690	785	910	955	—	15.0	22.1	22.1	38.9	61.1	69.0
	12	595	595	680	720	720	820	945	990	—	14.3	21.0	21.0	37.8	58.8	66.4
	13	625	625	710	750	750	855	975	1,025	—	13.6	20.0	20.0	36.8	56.0	64.0
	14	655	655	740	780	780	885	1,005	1,055	—	15.2	20.0	20.0	36.8	60.8	68.8
	15	685	685	770	810	810	915	1,035	1,085	—	15.2	20.0	20.0	36.8	65.6	73.6
	Maximum	715	715	800	840	840	945	1,065	1,110	—	15.2	20.0	20.0	36.8	68.8	77.6

* The salaries shown for 1950 include the increases paid to Permanent Secretaries, Deputy Secretaries, Under Secretaries and Assistant Secretaries as from 1st October, 1950 and the increases paid to Principals as from 1st August, 1950. The salaries of Assistant Principals were unchanged between 1st January, 1948 and 1st January, 1953.

APPENDIX I

TERMS OF STATEMENTS MADE ON THE GOVERNMENT'S ACCEPTANCE OF THE SPENS REPORTS

1. General medical practitioner report :

"The Minister desires to make his attitude to that report quite clear. He fully accepts the substance of the recommendations of the Committee in their majority report upon the general scope and range of remuneration which general practitioners should enjoy in a public service. The actual terms of remuneration cannot, however, be calculated from the recommendations by a simple process of arithmetic; the calculation involves consideration of a number of factors (e.g. the effect of a superannuation scheme and the percentage of betterment to be applied to pre-war figures) which are matters for discussion.

The Minister is consequently of opinion that the translation of the Spens recommendations into actual terms of remuneration . . . is a matter which must be discussed with the profession . . ."

(Letter of 22nd July, 1946, from Secretary, Ministry of Health, to Secretary, British Medical Association.)

2. Consultant and specialist report :

In reply to a Question in the House of Commons on 3rd June, 1948, as to when the report would be published, the Minister of Health (Mr. Bevan) said :

"The report will be available to hon. Members I hope tomorrow afternoon. I should like to add that the Government accept the recommendations in principle. The task of evolving from it the best scheme of actual remuneration to suit all cases—and especially the bearing of the recommendations on remuneration for teaching duties—will be difficult and will require the help of the profession in discussion. I propose to begin this quickly, but whatever final scheme emerges will be deemed to operate from the 5th July, even if discussions carry us past that date. Meanwhile interim contracts will be offered to specialists".

3. Dental Report :

There were the following questions and answers in the House of Commons on 27th May, 1948 :—

"Mr. Collins asked the Minister of Health if he accepts in principle the recommendations of the Committee on the Remuneration of General Dental Practitioners.

Mr. Bevan : Yes, Sir.

Mr. Collins : Can my right hon. Friend say when he hopes to be in a position to make an announcement in regard to the detailed application of these recommendations?

Mr. Bevan : Discussions are about to take place with the representatives of the dental profession, and I am hoping to reach a speedy conclusion."

APPENDIX II

TERMS OF STATEMENTS MADE ON THE STATUS OF THE SPENS REPORTS SINCE THE ORIGINAL SETTLEMENTS OF REMUNERATION IN THE NATIONAL HEALTH SERVICE

General

1. On 2nd July, 1952, the Chancellor of the Exchequer (Mr. R. A. Butler) made the following statement in reply to a question in the House of Commons whether he would make a statement arising out of the Danckwerts award:

"While the adjustment of salaries is a matter to be dealt with through the established negotiating machinery, the Government must be much concerned, as is this House, at any developments which might substantially affect the public purse and the general economic situation.

I want to make it clear that the terms of reference of Mr. Justice Danckwerts' award were confined solely to the question of the remuneration of general practitioners in the National Health Service and his award has no wider application. In accepting the results of the adjudication, which was of an exceptional nature, the Government have by no means adopted the view that similar adjustments in other fields should follow. In their view there is no justification for any assumption that the appropriate standard of remuneration for the professional classes is a rate of 100 per cent above that in force in 1939. They consider that remuneration should be determined in the light of all relevant circumstances."

2. In 1954, the following correspondence passed between the British Medical Association and the Ministry of Health:

Letter of 15th April, 1954, from the British Medical Association.

"It has been the policy of the Association, as determined by the Representative Body, to secure 'an adequate betterment factor' for consultants and specialists in conformity with the intention of the Spens Report. At its meeting during the first week in May, the Council will receive a report of the recent agreement in Committee "B" of the Medical Whitley Council and will have to decide what statement about this is to be included in its Report to the Annual Representative Meeting in July. I shall be grateful if you will kindly give me an answer to the question which is asked below, as this, I think, will help the Council to express an informed opinion on the matter.

The following is a quotation from Sir Russell Brain's published account of the Committee "B" agreement: "The Staff Side was left in no uncertainty as to the Government's policy in the matter and the attitude of the Management Side. It was quite clear that in no circumstances could a claim be considered for hospital staff based on the Danckwerts Award."

I am slightly puzzled by this statement of Government policy, for I understand that the Committee "B" agreement is in a sense "based on the Danckwerts Award". Indeed, Sir Russell Brain writes "The Staff Side is satisfied that the settlement it has achieved does, in fact, restore the balance between consultant and general-practitioner remuneration which was upset by the Danckwerts Award." At the same time it is quite clear that, whereas the Danckwerts Award went a very long way towards full implementation of the one Spens report, the Committee "B" agreement falls very far short of full implementation of the other Spens report.

The recommendations of the two Spens reports, considered together, present a proposed relationship between the financial rewards of general practice on the one hand and consultant practice on the other. My question is this. Would I be right in concluding that Government policy, while favouring the maintenance of an equitable relationship between the financial rewards of general practice and of hospital practice, is opposed to the recognition of what I may call the Spens relationship as the equitable one? Is this a correct statement of the view of the Government or of the view of the Minister of Health?

I hope that Mr. Macleod will see no objection to your giving me a clear answer to this question, because I think that the profession is entitled to know what his attitude is."

Letter of 26th April, 1954, from the Ministry of Health.

"Thank you for your letter of the 15th April about the recent pay agreement. The short answer to your question might best be put this way: that the Minister is certainly of the opinion that there should be a proper relationship between the financial rewards of general practice and of hospital practice; and that what constitutes a proper relationship must be determined in the light of all the relevant factors obtaining at any given time rather than by a mere reference back to the contents of Reports which were produced years ago and before there had been any experience of the working of the Service under modern conditions."

Letter of 6th May, 1954, from the British Medical Association.

"Your letter of 26th April was considered by the Council of the Association at its meeting today.

I was asked to inform you that the Council repudiates the suggestion as to the present status of the Spens Reports which appears to be implied in your letter, and that it has adopted the following resolution:—

RESOLVED: That the Council re-affirms its policy to adhere to the basis of remuneration enunciated in the Spens Reports."

Hospital Medical Staff

3. On 22nd July, 1954, in reply to a question in the House of Commons by Mrs. Jean Mann:

"what assurances were given to hospital staffs . . . as to the acceptance of the Spens recommendations; how far he proposed to accept these recommendations; and what steps are being taken to implement the Spens Report as applicable to hospital staffs"

the Minister of Health (Mr. Macleod) replied:—

"The recommendations in the Spens Report formed the basis for the terms and conditions of hospital medical staff which were agreed with the profession and published in 1949. In answer to the second and third parts of the question I should like to make clear the Government's view that the remuneration of medical practitioners cannot be settled by reference only to the recommendations of a report made six years ago before any experience had been gained of the National Health Service. As my right hon. Friend the Chancellor of the Exchequer said in this House on 2nd July, 1952, remuneration must be determined after taking into account all relevant circumstances. In the light of this, increased rates of pay have recently been introduced for hospital medical staff under an agreement with their representatives."

General dental practitioners

4. In 1953, the following correspondence passed between the Ministry of Health and the British Dental Association:

Letter of 22nd June, 1953, from the Ministry of Health.

"At our meeting on the 8th May, the representatives of the British Dental Association told us that before committing themselves to a fact-finding enquiry, they would like to know whether it was the Government's intention that dental remuneration should continue to be governed by the Spens Report, whether any alterations which might be made in the present rates as a result of the enquiry would have retrospective effect, and whether the enquiry would be so designed and conducted as to produce results as quickly as possible.

While able to give an immediate assurance that so far as the Health Departments are concerned the enquiry would be carried out with all possible speed, the Departmental representatives felt that it would be necessary to consult their Ministers on the other two points.

This has now been done, and I am writing to say that it is the view of the Minister of Health and the Secretary of State for Scotland that dental remuneration should in future be determined in the light of all the relevant circumstances,

including the experience of the National Health Service that has been accumulated since the 5th July, 1948, rather than by reference to the Spens Report, which, as you know, was drawn up before the service started."

Letter of 26th June, 1953, from the British Dental Association.

"It was with considerable astonishment and even greater concern that we learned of the view of the Minister of Health and the Secretary of State for Scotland, as to the manner in which dental remuneration should in future be determined. We would remind the Minister that the profession were induced to enter the National Health Service in the belief that the Government were satisfied as to what should be the proper remuneration for dentists, in the light of the findings of an independent Committee comparable to that which dealt with medical remuneration. Indeed, the Spens Dental Committee drew comparisons in their Report between the two professions and the standards of remuneration appropriate to them. There has been no suggestion so far as we are aware that the recommendations of the Medical Committee, under the same Chairmanship as the Dental Committee, are no longer relevant and it is difficult to comprehend why there should be any such suggestion concerning the Dental Committee's Report.

We can appreciate the desire of the Government to keep health service costs within reason, but clearly there must be some yardstick by which the remuneration of general dental practitioners is to be determined and nothing has happened during the five years the National Health Service has been in operation to lead to the conclusion that the principles laid down by the Spens Dental Committee were in any way misconceived.

It is pertinent to remind the Ministry that in 1948 the Government of the day were warned by the Association that initially there would be a flood of demand for treatment, but the Association's warning was ignored and when the demand came dentists had to meet it, otherwise there would have been wholesale complaints from members of the public that they were unable to obtain treatment which they expected they would be able to receive.

It does appear to us that the question at issue is of such great importance that a meeting between representatives of the Association and the Minister is essential, for clearly any enquiry into income and expenses and discussion of the Scale of Fees would be pointless without some definite principles in mind. Furthermore, how could the Association be expected to have faith in the stability of any new standards of remuneration arrived at in the light of such an investigation if the standards originally laid down after such detailed consideration by an independent Committee are now to be ignored.

We ask you to believe that we are willing to do our best to meet the views of the Minister in the hope of keeping the cost of the dental services within reasonable limits and we shall be happy to discuss the whole matter with the Minister and to hear any suggestions he has to make. Unilateral action in whatever sphere of negotiations never serves any useful purpose and only leads to resentment and we do hope, therefore, that the Minister will listen to what the Association have to say, that a cordial and useful discussion will take place and that a date for the discussion will be suggested soon."

5. The Minister saw a deputation from the Association on 20th July, 1953. Following is an extract from a note of the proceedings which appeared in the Supplement (page 46) to the British Dental Journal for 3rd November, 1953:—

"The interview with the Minister took place on July 20th, 1953, and the Association's representatives made it abundantly clear that the apparent suggestion that the Spens recommendations no longer held good was viewed with the greatest possible concern. The Minister was at pains, however, to emphasize that the position was not as imagined inasmuch as he still regarded the Spens findings as a factor, and an important factor, in dealing with dental remuneration. He added, however, that the conclusions of the Spens Committee could

not be regarded as the one and only factor. They had been reached before the National Health Service came into operation and it was only right and proper that regard should be had to experience gained during the last five years. His view, therefore, was that remuneration must be decided in the light of all the relative circumstances, of which the Spens Report was one.

The Minister also said that the Government's attitude with regard to doctors and dentists in the National Health Service was precisely the same."

APPENDIX III

DISTINCTION AWARDS

The Spens Committee's argument

1. After reaching the conclusion that the starting salary of a consultant appointed at the age of 32 should be £1,500 and that specialists of the highest eminence should be able, in the public service, to aspire to a remuneration of the order of £5,000 for clinical work, the Spens Committee found themselves faced with the question of what should be the spread of incomes between £1,500 and £5,000 and of how such a spread could be realised. They said:

"We are satisfied that there is a far greater diversity of ability and effort among specialists than admits of remuneration by some simple scale applicable to all. If the recruitment and status of specialist practice are to be maintained, specialists must be able to feel that more than ordinary ability and effort receive an adequate reward. Moreover, a reward which would be appropriate when these exist would be extravagant when they do not. In consequence we are clear that any satisfactory system of remuneration must involve differentiation dependent on professional distinction." (Spens Report, Section 13.)

2. The Committee concluded that all consultants should be paid on a salary scale which would progress from the minimum to the maximum by eight annual increments, the maximum being reached at the age of 40 if consultant status was achieved at the age of 32, and that thereafter remuneration should no longer depend in any way upon length of service.

3. The Committee proceeded to consider in what way a satisfactory spread of incomes could be obtained in the higher age range—by which they seem to have meant the early 40s. onwards—and what should be the method of differentiation between consultants to achieve this spread and to ensure that in the lower age range also outstanding ability should be rewarded by remuneration in excess of the standard salary scale. The Committee's conclusion was that there should be distinction awards in three grades which would be conferred on selected consultants in recognition of special contributions to medicine, exceptional ability or outstanding professional work other than administrative; and that these awards should be conferred on 34 per cent of all consultants, 4 per cent receiving the highest award, 10 per cent the second and 20 per cent the third. The Committee envisaged that the effect would be:—

"that approximately one-third of all specialists will receive more than the basic salary of £2,500."

It should be noted that £2,500 was the maximum of the recommended basic salary scale and if those words are taken at their face value the Committee seem to have had in mind that almost all awards would be conferred on consultants who had already reached the maximum of the basic scale. It is, however, conceivable that by the words "the basic salary of £2,500" the Committee meant "the basic salary scale rising to £2,500".

The views of the profession

4. Though the volume of correspondence on awards published in the lay and professional press does not suggest that any large proportion of the medical and dental profession is opposed to the present system, some criticism of it has appeared

in published letters⁽¹⁾ from members of the profession. The main points of criticism in these letters have been :—

- (a) The objection that public funds are distributed to unnamed consultants in a manner not made public.
- (b) The difficulty of distinguishing between the quality of the work of different consultants.
- (c) Uncertainty about the criteria used by the Awards Committee in making recommendations and fear that undue preference may be given to certain sections of the body of consultants.
- (d) Dissatisfaction that no formal regional advisory bodies have been set up to give advice to the Awards Committee.
- (e) Individual consultants' uncertainty whether their claims for an award had been kept under review.

5. In the course of correspondence in the medical journals in 1954 the following letters appeared from the Chairman and Vice-Chairman of the Awards Committee :—

Letter from the Chairman

" When the system of merit awards began, we early felt that we could not hope for any measure of accuracy in the distribution of these awards without a drastic decentralisation of the machinery for gathering information. We realised that we could only succeed by getting into direct contact with local opinion. For this purpose, Sir Horace Hamilton, the vice-chairman of the Awards Committee, and I set aside three months of the year in order to visit each region. No one procedure has been found which meets every circumstance. For instance, in the Birmingham region this year, apart from the teaching hospital, meetings were arranged at Stoke, Wolverhampton, Coventry and at the two municipal hospitals, Dudley Road and Selly Oak. In the Bristol region we went to Truro, Exeter, Plymouth, Bath and Bristol. On the other hand, at Newcastle, we could always be sure that between 200 and 250 specialists, gathered from the whole region, would come to an evening meeting, year after year. At these meetings we invite questions, and generally speaking full advantage is taken of the opportunity of frank discussion—at Newcastle, for example, the debate lasted more than two hours. In short sometimes we go to the various parts of the region, sometimes they come to us. In London, the three Royal Colleges give the Committee most valuable and detailed help, paying particular attention to the claims of specialists not attached to teaching hospitals. Further information comes from one or more advisers in each specialty, while each of the four Metropolitan Regions is divided up into sixteen or eighteen areas, with advisers in each area.

These meetings over the whole country, to which all specialists in the area concerned are invited, are invaluable to us as a means of meeting consultants and learning their views, often outspoken; but a large gathering plainly could not be expected to bring forward recommendations to fill vacancies in the list of awards. So in the first instance the meetings were asked to elect small sub-committees to advise us—precisely the machinery suggested now by the Council of the Regional Hospitals' Consultants and Specialists Association in their letter⁽²⁾. But experience (three years' trial and error) has shown that a committee is not always the ideal method of eliciting the particular information we require. In this connection I recall that at the outset some of the London teaching hospitals, in response to our request for recommendations, decided of their own accord to entrust the task to two or three of their staff, who were instructed to report direct to the Awards Committee, and not to the parent medical committee which had appointed them. There was a feeling that it was not fair to ask those who had been given this difficult task to submit

⁽¹⁾ See list at end of this Appendix.

⁽²⁾ British Medical Journal, Supplement, 26th June, 1954, p. 359.

their conclusions, which were obviously of a confidential nature, in open committee, to perhaps as many as thirty members. For they were asked not merely to submit a list of names to fill vacancies: it was necessary to supply the Awards Committee with the reasons which had led to the choice of those names. And it was found that many consultants were not prepared to furnish these reasons save to the Awards Committee, where they could feel assured that the confidential nature of their report would be respected. In many instances we learnt that areas outside the teaching hospitals came quite independently to the same conclusion and preferred to entrust the task to one or two senior consultants who enjoyed the confidence of specialists in those parts. Nevertheless, when this view is not accepted, where in brief a meeting of specialists would prefer to entrust this task to a small committee, the Awards Committee will always welcome whatever advice they may give. For the master principle that has guided us from the beginning of our selection for Awards has been to gather advice concerning any individual from as many sources as possible. So only can we hope to eliminate prejudice and to attain to some degree of accurate appraisal. And here let me express the gratitude of the Awards Committee to the very large numbers of specialists who by their detachment and good sense have made the successful working of this method of remuneration possible.

I have spoken of the successful working of the awards system. Am I entitled to make any such claim? The letter to the Supplement signed by Mr. John Simons⁽¹⁾ on behalf of an association which he represents (which is not to be confused with the Central Consultants and Specialists Committee of the British Medical Association) has not been followed up, so that it is perhaps necessary to remind your readers that he would flatly deny my claim. What then is the truth? There are more than 6,000 specialists in England and Wales. Of these a majority have not been given a merit award, and it is perhaps inevitable that there are some who are not satisfied with the Committee's selection. More, it would probably be possible, with a little organisation, to whip up a number of letters in support of Mr. Simons' assertion. That there is "considerable disquiet" is, however, diametrically opposed to our experience. On our recent tour of the country the meetings were very large, the attendance was often twice what it had been in previous years, and there appeared to be a very generous appreciation of the time and trouble that the Committee gave to the task in hand and of the success that had attended its attempt to overcome the more obvious difficulties inherent in such a system. There are a number of bodies representing specialists and, if the Awards Committee have not made full use of this particular association, it is never too late to amend our ways. In England, when we do anything remarkable it is our custom to hasten to deny that it is anything out of the way. The body of specialists in England and Wales have taken this system of merit awards, and by their individual help and advice have made it work. It is indeed a remarkable achievement which has its roots in the good sense of our people, an achievement, I think, beyond the reach of more selfish countries."

Letter from the Vice-Chairman

"In the correspondence on merit awards seven consultants have taken part, and, of these, three were very much concerned with the relative remuneration of surgeons and anaesthetists, a question which to the layman seems somewhat remote from awards. In the circumstances it would, I suggest, be difficult to contend that these letters, either in number or content, afford evidence of widespread dissatisfaction with the way the system is working. For the past three or four years I have, as vice-chairman, accompanied Lord Moran to meetings in many parts of the country and I have met many consultants both at the meetings and informally. This year the meetings were larger than in previous years and they struck me as lively and interested; signs of hostility were few and far between. There was certainly no evidence that consultants generally regarded the awards system as being worked unfairly.

(1) British Medical Journal, Supplement, 26th June, 1954, p. 359.

I realise, of course, how difficult it is for any of your correspondents in the absence of detailed information to decide whether the system is working with reasonable accuracy. Lord Moran has, however, already explained in this correspondence how the Committee sets about its task—the central and peripheral machinery for collecting evidence. And perhaps I might be allowed to say, as one who in other fields has been familiar for many years with problems of selection, that, so far as I can judge, the existing arrangements are well adapted for their purpose—namely to provide as much information as possible from many different sources in order to furnish the necessary checks and counter-checks. That these arrangements have proved efficacious is due to the invaluable assistance given by consultants everywhere, as Lord Moran has pointed out. In this connexion I hope that Dr. Bathurst Norman on reflection will regret the use of the word “informers” with all its sinister implications, in referring to distinguished and respected members of his profession. The question of “secrecy” has been raised. When the awards system was introduced it was brought to our notice that, if the names of consultants with awards were published, the public might press to be seen and treated by consultants with awards and that this might be unfair to those who had not yet got an award.

One of your correspondents, Mr. H. J. McCurrah⁽¹⁾ raises the question whether teaching hospitals are unduly favoured and repeats a statement that “every member of a teaching hospital above the age of 40 received a merit award”. This is untrue. On nothing has the Committee laid more stress than that these awards should be given for professional distinction alone, and that it was entirely irrelevant whether a consultant was attached to a teaching hospital or not. Apart from this guiding principle there are good reasons, as the Spens Committee pointed out, for spreading these awards over the country. The Spens Committee held that in providing a consultant service a measure of decentralisation of specialists was essential, so that they do not all congregate in the great centres of population; the Awards Committee is fully conscious that a proper distribution of the awards can help in carrying this out. It is indeed the main purpose of our visits to various parts of the country to see that consultants working outside the great cities are not forgotten. The Committee is convinced that the system can only be worked fairly by getting into contact with consultants all over the country and I believe from what I have learnt in the course of our travels that there is a pretty general feeling that the Committee is doing its best to administer the system fairly and without prejudice.

6. In July, 1956, the Annual Representative Meeting of the B.M.A. decided that consideration should be given to the desirability of abolishing the distinction awards system. In December, 1956, the Central Consultants and Specialists Committee of the B.M.A. expressed their confidence in the Awards Committee and its working. This view was accepted first by the Council of the B.M.A. and later by the Annual Representative Meeting in July, 1957.

List of letters mentioned in paragraph 4 above

LANCET:	27th November, 1954 (p. 205).
26th June, 1954 (p. 359).	1st January, 1955 (p. 6).
24th July, 1954 (p. 197).	29th January, 1955 (p. 33).
BRITISH MEDICAL JOURNAL:	19th February, 1955 (p. 59).
30th April, 1955 (p. 1045).	14th January, 1956 (p. 11).
25th June, 1955 (p. 1531).	4th February, 1956 (p. 39).
BRITISH MEDICAL JOURNAL (SUPPLEMENTS):	18th February, 1956 (p. 57).
26th June, 1954 (p. 359).	24th March, 1956 (p. 104).
24th July, 1954 (p. 78).	31st March, 1956 (p. 115).
31st July, 1954 (p. 85).	18th August, 1956 (p. 108).
21st August, 1954 (p. 97).	5th January, 1957 (p. 15).
4th September, 1954 (p. 109).	12th January, 1957 (p. 20).
18th September, 1954 (p. 122).	18th January, 1958 (p. 23).
30th October, 1954 (p. 161).	25th January, 1958 (p. 37).
6th November, 1954 (p. 174).	1st February, 1958 (p. 48).
13th November, 1954 (p. 185).	8th February, 1958 (p. 64).
20th November, 1954 (p. 196).	22nd February, 1958 (pp. 83 and 84).
	8th March, 1958 (p. 103).

⁽¹⁾ Letters in British Medical Journal, Supplement, 24th July, 1954 and 21st August, 1954.

APPENDIX IV

LENGTH AND COST OF TRAINING; AND FINANCIAL ASSISTANCE FOR STUDENTS

Length of Training

1. The recommendations of the General Medical Council lay down that professional study should be for a period of not less than five academic years for medicine and of not less than four years for dental surgery. In fact the period is usually longer.

2. Information supplied by the University Grants Committee is that:—

- (a) it takes longer to obtain a first degree in medicine than in most other subjects;
- (b) the regulations for first degrees in medicine are practically uniform throughout the medical schools in the United Kingdom. Satisfactory attendance is required during at least five years (generally six) at recognised courses of study and hospital practice for the award of a first degree;
- (c) the period of study for a first degree in dentistry is generally about five years;
- (d) veterinary science takes about 5½ years and some degrees in architecture take five or six years; first degrees in arts (including law) and science may be awarded after the satisfactory completion of a three or four years' course;
- (e) higher degrees may be taken in all faculties after further periods of study, the length of time taken depending on the type of higher degree and the particular university regulations.

3. Other examples of the comparative length of professional training may be cited. Before being allowed to practice in their profession solicitors must have undergone a period of training of at least 5–6 years. Similarly, before becoming an Associate member of their respective professional Institutions, civil engineers and chartered accountants must have undergone a period of training of not less than 5–6 years, and actuaries a period of 7 years or more.

4. All medical graduates or diplomates have to engage in hospital employment as a house officer for twelve months before they can become fully registered medical practitioners. During this employment, which is resident, they are paid at the rate of £467 10s. 0d. a year for the first six months and £522 10s. 0d. a year for the second six months—both rates include the 10 per cent interim increase given to junior medical staff in 1957—and they are charged at the rate of £125 a year for board and lodging.

Annual Cost of Training

5. The University Grants Committee state that for the academic year 1957–58 and subsequently all universities (except Oxford and Cambridge) have agreed to adopt the following minimum inclusive annual tuition fees for first degrees:

Arts	... ..	£50 (£38 in Scotland)
Science and technology	... ..	£60
Medicine and dentistry	... ..	£60

The Committee have no general information about the cost of books and instruments, which are additional to the above fees and which for medicine and dentistry may be considerable. (For the academic year 1957–58, the University of Liverpool reported that the costs of books, instruments, etc. for the whole course are £77 (including £40 for books) for medicine and £142 (including £30 for books) for dentistry.)

6. Information obtained from the prospectus of University College of the University of London shows that the approximate annual tuition fees were as follows:—

B.A.	£52-£62 according to subjects taken
B.Sc.	£57-£67 according to subjects taken
Medicine	£65-£67 according to year of training
Dentistry	£65

Not all London colleges charge the same fees but it is understood that the differences are not significant.

Financial assistance for students

7. Like other university students, many medical students receive financial assistance from public or private funds during their training. It is understood that the Ministry of Education has supplied the Commission with information about the assistance available from public sources in the form of State Scholarships or awards given by Local Education Authorities.

The grants payable depend on the individual university, the lodging of the student, the parental income, and the family circumstances. The following illustration shows the point at which entitlement to grant (apart from an honorarium in the case of State Scholarships) is extinguished if the student is reading medicine at Oxford University:—

<i>Number of children in family</i>	<i>Number of children at Fee-paying school</i>	<i>Scale Income</i>
1	—	£2,470
2	1	£2,770
3	2	£3,070
4	3	£3,370

Parents with scale incomes below these maxima would benefit from grants.

8. The Ministry of Education state that payments, additional to the normal financial assistance provisions covering all students, are made to medical and dental students towards the cost of instruments (e.g. half-skeletons, microscopes, ophthalmoscopes and dental instruments). The payments for dental instruments are at present under review by the Ministry.

9. The University Grants Committee state that in 1955-56 nearly 75 per cent of full-time university students held scholarships, exhibitions or other awards from public or private funds which provided wholly or in part for the payment of fees and other expenses (see page 7 of the Committee's Returns from Universities and University Colleges for 1955-56 (Cmd. 211)). Information supplied by the Ministry of Education shows that of 10,568 State Scholarships current in England and Wales in the academic year 1956-57, 1,199 and 51 were held by scholars who were studying medicine and dentistry respectively. The Ministry of Education do not know what proportion of Local Education Authority Award holders are medical and dental students.

10. A report "Applications for Admission to University" by R. K. Kelsall published by the Association of Universities of the British Commonwealth indicates that whilst the percentage of students resident in the U.K. who were admitted in 1955-56 to a full-time course of study leading to a first degree or diploma and who received no financial assistance of any kind was 19 per cent for men and 21 per cent for women for all faculties taken together, the corresponding percentages for medicine were higher being 33 per cent for men and 30 per cent for women: for dentistry, the figures were 32 per cent for men and 38 per cent for women. The report suggests that this is explained in part at least by the fact that medicine and dentistry (with agriculture) contained the highest proportions of students coming

from the professional and managerial classes. The report also shows that the sources of financial assistance were as follows:—

Source of Grant	Medicine		Dentistry		All faculties	
	Men	Women	Men	Women	Men	Women
1. No information obtained from students	per cent	per cent	per cent	per cent	per cent	per cent
2. No assistance	0.5	0.2	0.3	0	0.6	0.2
3. University scholarship, bursary, etc.	33.0	29.6	32.3	37.8	19.3	20.5
4. State Scholarship	5.4	5.3	1.1	1.4	8.3	4.8
5. L.E.A. grant	5.8	8.1	2.7	2.7	9.7	9.9
6. Other sources	53.5	55.6	60.8	54.0	58.5	62.6
	1.8	1.2	2.8	4.1	3.6	2.0

APPENDIX V

RELATIVITY BETWEEN GENERAL MEDICAL PRACTITIONERS AND GENERAL DENTAL PRACTITIONERS

1. The Spens Committee for General Dental Practitioners considered that as compared with a net annual income of £1,800 for a general medical practitioner, a general dental practitioner should receive £1,600. These figures were in 1939 values. The Committee's recommendation of £1,600 a year net for a general dental practitioner related to an experienced single-handed dentist working efficiently and making full use of all appropriate assistance, fully employed but not working longer hours than 33 a week by the chairside for 46 weeks in a year or, say, 1,500 chairside hours a year together with the hours necessarily spent outside the surgery.

2. With the increase of 20 per cent, made as an adjustment to 1948 circumstances, the £1,600 a year net recommended by the Spens Committee became £1,920 net, including the value of the Exchequer superannuation contribution. This figure of £1,920 net for single-handed dental practitioners, making full use of all appropriate assistance and working efficiently for 1,500 hours a year at the chairside, compared with the average of £2,055 net for all general medical practitioners which followed from the betterment factor of 85 per cent which Mr. Justice Danckwerts considered would be appropriate for such practitioners in 1948.

3. A differential was maintained in the new agreement on remuneration reached between the Ministers and the British Dental Association in 1955. In introducing in the House of Commons on 12th July, 1955, the Supplementary Estimate to cover the additional cost entailed by the new agreement in the current financial year, the Minister of Health said:

"Under the new arrangement, average dentists will receive, including the Exchequer superannuation contribution, about £2,000 net. That compares with the general practitioner's average net income of rather more than £2,200. But it is calculated that single-handed dentists working without assistants, in the class with which the scale is particularly concerned, the 35-54 years old age groups, will receive rather more than £2,400 net, so I think that the relativity between dentists and doctors in general practice has been kept well in mind as these arrangements were made."

APPENDIX VI

SUGGESTED METHOD OF MAKING AN ESTIMATE OF INCOME FROM PRIVATE
GENERAL MEDICAL PRACTICE IN 1952-53

(a) The information obtained by the Board of Inland Revenue from the Income Tax returns of the 1,782 doctors included in the sample for the practice expense enquiry for 1952-53 will include the gross professional income of each of these doctors.

(b) There is also available for each of these doctors the amount of their earnings in 1952-53 from:—

- (i) the National Health Service (general practice and hospital work)
- (ii) local authorities
- (iii) government departments.

(c) The aggregate of the professional incomes for these 1,782 doctors minus the aggregate of their earnings under the headings in (b) would represent their earnings from private practice (including fees for life insurance examinations, for giving anaesthesia for dental operations, for factory and industrial medical services not remunerated from public funds, etc.).

(d) The figure of private earnings of these 1,782 doctors ascertained in that way might be grossed up to give an estimate of private earnings for all general practitioners in unrestricted practice (18,986) in 1952-53.

(e) An appropriate adjustment should be made for the 1,479 doctors who were excluded before the sample for the 1952-53 enquiry was drawn.

ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

CIVIL SERVICE SALARIES

Memorandum by the Treasury

The salaries and other conditions of service of civil servants are based largely on the recommendations of the Royal Commission on the Civil Service, 1953-1955 (referred to in this note as the Priestley Commission). This Commission, a summary of whose Report⁽¹⁾ is at Appendix⁽²⁾, made recommendations on the principles to be adopted in determining the pay of civil servants (excluding industrial civil servants) and on the hours of work, annual leave and rates of pay which it considered appropriate in the light of those principles.

Principles of Pay

The Priestley Commission considered that the pay of civil servants should be determined primarily by fair comparison with the current remuneration of staffs in other occupations employed on broadly comparable work, taking account of differences in other conditions of service. In the course of subsequent discussions on the National Whitley Council this principle was accepted without reservation by the Official Side, and by the Staff Side as a valid and valuable principle in Civil Service pay negotiations though not as the sole determinant.

Machinery for Determining Pay

The same principle of fair comparison had been laid down by the Tomlin Commission (1929-31) on the Civil Service. But the Priestley Commission reaffirmed and clarified it, and struck new ground in their recommendations about its application.

Pay Research Unit

The Commission found that in earlier years the arrangements for the collection of information about comparable occupations for each of the many civil service grades had not been wholly satisfactory. They therefore recommended the setting up of an impartial organisation to carry out this work. This recommendation has been put into effect and a Civil Service Pay Research Unit has been set up to investigate and report on the pay and other conditions of service of staffs in other employments engaged on work broadly comparable to that of particular grades of civil servants. The Unit reports both the facts about outside occupations and how their work compares with that of the civil servants concerned. The Unit works under the general control of a Steering Committee drawn from both Sides of the National Whitley Council. The material which it provides forms the basis on which negotiating parties can subsequently discuss appropriate rates of pay and other conditions of service.

The recent settlement giving increased pay to the manipulative grades in the Post Office is the first case of a pay claim which has been negotiated and settled with the aid of material supplied by the Pay Research Unit. Other material is now being collected by the Unit, and, when this is ready, the Departmental and Staff Side representatives concerned will open negotiations based on it. When the Pay Research Unit has got into its stride, it will have a good deal of information in its pigeon-holes; and then most pay negotiations will be conducted on the basis of its material. But this position has not yet been reached, and in the meantime there will be negotiations on the lines which prevailed before the Unit came into existence. This does not mean that the principle of fair comparisons will not play its part in those negotiations. It has always been one of the factors taken into account, though in the past the material has been collected by rather more crude methods and the negotiators using it have not had the benefit of a scientific assessment of comparabilities.

(1) Cmd. 9613.

(2) Appendix A is not reproduced in this volume. This summary of the Report of the Royal Commission on the Civil Service was printed in the Summer 1956 issue of "Public Administration", published by the Royal Institute of Public Administration.

Advisory Committee on the Higher Civil Service

Another recommendation of the Priestley Commission was concerned with the machinery for settling the pay of the Higher Civil Service. At most levels of pay in the Civil Service there is provision for a reference to the Civil Service Arbitration Tribunal if negotiations on a pay claim break down. But the Staff Side have not the right to go to arbitration on the pay of grades higher than the Principal in the Administrative class, i.e. broadly in respect of any grade with a maximum salary in excess of £2,050. The Priestley Commission considered whether there should not be some special and independent machinery for reviewing the pay of these higher grades. They came to the conclusion that:—

"There should be appointed a Standing Advisory Committee, of say, 5 persons, chosen to reflect a cross-section of informed opinion in the country at large, with the function of exercising a general oversight of the remuneration of the higher Civil Service."

Such a Committee, under the Chairmanship of Lord Coleraine, was appointed in January of this year. The other members are Sir Alexander Carr-Saunders, Sir Geoffrey Crowther, Sir Alexander Fleck, Sir Oliver Franks, and Lord Latham.

It should be emphasised that:

- (a) there is no question of the Coleraine Committee being an arbitration tribunal for the higher Civil Service. The Committee review the levels of pay in this section of the Service either at the Government's request or on their own initiative. The staff have no right of access to the Committee. If, however, it proves impossible to reach an agreement in negotiation on claims relating to the pay of grades in the higher civil service involving major issues, the Staff Association concerned are entitled to ask the Treasury to invite the Committee to examine the claim and the Treasury have an obligation to comply with this request.
- (b) The Committee's recommendations are not binding on the Government.

If the Royal Commission on Doctors wish to study the recommendation of the Priestley Commission on this piece of machinery, reference should be made to paragraphs 377-391 of the Commission's Report.

The Committee has no formal terms of reference other than the recommendation of the Priestley Commission, nor has it laid down any precise procedure which it intends to follow in discharging its task. It has, however, made plain its intention—in accordance with the Priestley Commission's recommendation that it should be concerned solely with important questions affecting the general level of higher Civil Service remuneration—to confine itself to major matters of pay structure, and to offer such recommendations as it may make in fairly general terms, leaving the detailed implementation to the Treasury or other departments concerned and the staff associations. On the one reference so far made to it (see below) the Committee received a factual memorandum agreed between the Treasury and the Staff Side. Each side was then asked to put in its own suggestions in writing for the Committee's consideration and was given an opportunity to comment in writing on the other side's suggestions. The Committee made its recommendations with this material before it.

Hours and Leave

The Priestley Commission recommended that the hours of work of office staff should be, in London 42 hours gross (i.e. inclusive of meal intervals), and in the provinces 44 hours gross. This recommendation was accepted by both Sides of the National Whitley Council. The Commission recommended new scales of annual leave allowances based on length of service and on the maximum salary of an officer's grade. This system was adopted with some modifications, but reserved rights were given to officers who already had more favourable leave conditions in their existing grades.

Increases in Pay in Recent Years

The Priestley Commission, in the light of the principles outlined above, prescribed rates of pay designed to equate the pay of the different civil service grades with pay in other comparable employments. The rates so laid down gave comparable remuneration as at 1st July, 1955. These rates have since been increased as follows:

- (a) as from April, 1956, by some 5½ per cent in respect of grades up to the level of £1,950;
- (b) as from April, 1956, in respect of grades paid more than £1,950 as follows:
- | | | | | |
|---|-----|-----|-----|------|
| Up to but not including £2,850 | ... | ... | ... | £100 |
| From £2,850 to £3,450 | ... | ... | ... | £150 |
| Above £3,450—to bring them up to £3,600 | | | | |
- (c) as from 1st July, 1957, in respect of grades up to the level of £1,950 by some 5 per cent.

(a) and (c) have been general increases given because of the general rise in outside occupations, coupled with the fact that the Pay Research Unit is not yet in a position to produce the data required to enable fresh determination to be made grade by grade.

(b) was the result of a reference to the Advisory Committee on the Higher Civil Service made to ascertain, whether, as a result of the general increases given to the rest of the Civil Service, any increases were required for the higher grades; a further reference will no doubt be made as a result of (c).

Provincial Differentiation in Pay

The rates of pay quoted in this memorandum are London male rates, payable to civil servants whose offices are within a 12-mile radius from Charing Cross. These rates are subject to a deduction of approximately 3 per cent (with a maximum deduction of £50) for civil servants in offices in intermediate areas, i.e. the London periphery and the larger towns, and of approximately 6 per cent (with a maximum deduction of £100) in provincial areas, i.e. elsewhere.

Under a new scheme which has been provisionally agreed (subject to ratification by Staff Associations) this system will be replaced by a national rate, based on the present intermediate rate, to which provincial areas will be gradually assimilated over a period of 4 years from 1st January, 1958. Offices in the London area (which is to be extended from 1st January, 1958, to a 16-mile radius from Charing Cross) will qualify for a London allowance based on the present differential between London and intermediate rates.

The Main Classes

The Royal Commission devoted part of its Report (especially Chapter IX) to the Higher Civil Service above the level of Administrative Principal. The Chapter, which is too long to quote in full, contains some useful material on the comparability of the higher civil servant with representatives of other occupations.

The following are the classes of civil servants containing grades remunerated at levels approximately corresponding to those of doctors in the National Health Service. A brief note of the work done by these classes is in the Appendix noted against each.

Administrative Class	...	...	...	...	Appendix B
Executive Class	...	...	...	...	Appendix C
Scientific Officer Class	...	...	...	...	Appendix D
Works Group of Professional Classes	...	...	...	...	Appendix E
Legal Class	...	...	...	...	Appendix F
Medical Class	...	...	...	...	Appendix G

The attached Table A gives the rates of pay of officers in these classes in 1939, 1950-51, as recommended by the Royal Commission and as now in force.

TABLE A
Higher Civil Service

Class and Grade	1939	1950-1951	Per cent. Increases over 1939	Royal Comm. Recommendations.	Per cent. Increases over 1939	1957	Per cent. Increases over 1939	Notes
<i>Administrative Class</i> Permanent Secretary to the Treasury.	£ 3,500	£ 5,000	42-85	£ 7,000	100	£ 7,000	100	Now 2 joint Secretaries at £6,500 (85-71 per cent.).
Permanent Secretary	3,000	4,500	50	6,000	100	6,000	100	
Deputy Secretary ..	2,300	3,250	47-72	4,250	93-18	4,250	93-18	
Under Secretary ..	1,700*	2,500	47-05	3,250	91-17	3,400	100	*Principal Assistant Secretary—not precise equivalent.
Assistant Secretary	1,150-1,500	1,500-2,000	33-33	2,000-2,600	73-33	2,100-2,700	80	*The titles of the grades in this class were changed in 1946: the 1939 rates of pay relate to the grades then existing when aligned with the present grades.
<i>Scientific Class</i> Post above Chief Scientific Officer.	Various rates up to 2,000	4,300 3,750 3,250 2,850	125 87-5 62-5 42-5	Broadband 3,500-6,000	75-200	Broadband 3,500-6,000	75-200	
Chief Scientific Officer.	Various grades between 1,350 and 1,650	2,500	51-51	(i) 3,250 (ii) 3,000	96-96 81-81	(i) 3,400 (ii) 3,150	106-06 90-9	
Deputy Chief Scientific Officer.	1,650	1,850-2,125	57-4	2,400-2,700	100	2,500-2,800	107-4	
Senior Principal Scientific Officer.	1,050-1,250	1,500-1,750	40	2,000-2,300	84	2,100-2,400	92	
<i>Worker Group</i> Directing Posts ..	Various rates and scales up to 2,500	3,500 3,250 2,750 2,500 2,250 2,000	Up to 40	Broadband 3,250-5,000	Up to 100	Broadband 3,150-5,000 3,000 2,700	Up to 100	

Superintending Grade.	(i) 953— 1,161 (ii) 1,050— 1,200	1,500—1,750	(i) 50·73 (ii) 45·85	2,000—2,300	(i) 98·1 (ii) 91·66	2,100—2,400	(i) 106·71 (ii) 100
<i>Executive Class</i> Heads of Certain Principal Executive Officers.	1,450—1,650 1,150—1,450	Various rates 2,000—2,500 1,500—1,900	21·21—51·51 31·03	Various rates 2,600—3,250 2,300	57·57—96·96 58·62	Various rates 2,700—3,400 2,400	63·63—106·06 65·51
<i>Legal Class</i> Principal Assistant Solicitor.	1,400 and 1,650 1,200—1,400	2,500 1,625—2,000	51·51 42·85	3,250 2,100—2,600	96·96 85·71	3,400 2,200—2,700	106·06 92·85
<i>Medical Class</i> Chief Medical Officer Senior Posts in various depart- ments.	2,200 Various rates and scales between 1,200 and 1,650 1,200— 1,400	4,000 (a) 3,000 (b) 2,850 (c) 2,500	81·81 81·81 72·72 51·51	5,000 Broadband 3,250—3,750	127·27 96·96— 127·27	5,000 Broadband 3,400—3,750	127·27 106·06— 127·27
Principal Medical Officer.	(a) 1,400— 1,600 (b) 1,050— 1,300	2,250 1,800—2,000	60·71 25 53·84	2,850 2,600	103·57 62·5 100	3,000 2,700	114·28 68·75 107·69
Senior Officer.	(a) 850— 1,200 (b) 750— 1,000	1,250—1,725	43·75 72·5	1,650—2,250	87·5 125	1,825*—2,350	95·83 135
Medical Officer ...							

Note: Where minima and maxima are shown, the increase has been calculated on the maxima.

* These figures include temporary additions to pay, consequent upon the 5 per cent increase of 1st July, 1957. They are payable on that part of the scale up to the level of £2,050 (including the temporary addition). The amounts of the temporary additions between £1,950 and £2,050 are such as to bring the increased salary up to £2,050.

APPENDIX A

(see footnote on page 769)

APPENDIX B

THE ADMINISTRATIVE CLASS

Duties

The duties of the administrative class include the formation of policy, the co-ordination and improvement of Government machinery and the general administration and control of the Departments of the public Service.

In paragraph 415 of its Report the Royal Commission on the Civil Service said:—

"The members of the administrative class must be able to work from a very broad Government aim, first to thinking out a policy for the execution of that aim and satisfying Ministers that it correctly interprets the aim, secondly to putting that policy into legislative form and thirdly to its translation into action, frequently on a national basis. The effective discharge of this function requires a distinctive organisation and the deployment of officials with qualifications and experience for which no direct comparison can be found outside. These duties have to be carried out in ways compatible with Ministerial control, the accountability of Ministers to Parliament and their accountability, in a less direct but very real sense, to public opinion. The civil service administrator must have a general ability to understand and allow for the interaction of these three elements in the formulation of new Government policy and the execution of established policy. This cannot be developed without a long period of working closely with and directly for Ministers, who bring to the work their special knowledge of the political side of government. Again the civil service administrator must have the ability to acquire a clear, extensive and detailed knowledge of the government machine and how it works. The machine is unavoidably complex and it must be thoroughly understood if it is to be operated to best advantage. It is mainly in the grades of principal and assistant secretary that opportunities are provided for members of the class to acquire the necessary knowledge and experience. In these grades, and increasingly so in the higher grades, responsibility is taken for preparing briefs for Ministers and papers for the Cabinet and for seeing Bills through Parliament. These tasks demand an ability to master and apply complicated techniques and to produce results which in appearance are often deceptively simple. Frequently the more important the issue, the shorter the notice and the greater the atmosphere of stress and strain under which the work must be carried out."

Numbers and Pay

The class is divided into the following grades:

<i>Grade</i>				<i>Number of Posts</i>	<i>Pay (Male London Rates)</i>
					£
Permanent Secretary	...	...	...	30	6,000
Deputy Secretary	...	...	...	62	4,250
Under Secretary	...	...	...	219	3,400
Assistant Secretary	...	...	...	682	2,100-2,700
Principal	...	...	...	1,233	1,450-2,050
Assistant Principal	...	...	...	241	635-1,110
				<u>2,467</u>	

Structure

The structure of the class may be described in the following general terms. The permanent secretary is the official head of the Department and is responsible to the Minister for all the activities of his Department. He will be assisted by 1 or 2 deputy secretaries. Below this there will be from 4 to 12 under secretaries carrying responsibility for advising Ministers either directly or through their supervisors, on major questions of policy and, as a rule, co-ordinating very large blocks of administrative work. Each under secretary will be assisted by a varying number of assistant secretaries in operational control of divisions and carrying responsibility for all day-to-day work done in the division. It is only questions of major policy that should normally be referred above this level. Each assistant secretary is supported by from 2 to 5 or 6 principals or senior executive staff, each of whom will be in charge of a branch or section of a division. He will in his turn be supported by a varying number of executive and clerical staff. Assistant principals form a training grade.

Recruitment

Recruitment to the assistant principal grade is either by open competition held annually for candidates between the ages of 20½ and 24, or by limited competition for established civil servants between the ages of 21 and 28.

APPENDIX C

THE EXECUTIVE CLASS

Duties

The duties of the executive class may be summarised as the day-to-day conduct of government business within the framework of established policy. They also include supply, finance and accounting work and other specialised work not requiring professional qualifications.

Numbers and Pay

The class includes the following grades :

<i>Grade</i>	<i>Number of Posts</i>	<i>Pay (Male London Rates) £</i>
Heads of Major Establishments	23	2,700-3,400
Principal Executive Officer	88	2,400
Senior Chief Executive Officer	250	1,995*-2,100
Chief Executive Officer	714	1,720-1,935
Senior Executive Officer	2,683	1,350-1,605
Higher Executive Officer	8,819	1,110-1,285
Executive Officer	24,026	385-1,050
	<u>36,603</u>	

The Royal Commission made the following remarks about the executive class :—

"The heads of major executive establishments include such posts as the director of savings, Post Office Savings Department, directors of accounts and accountants general in a number of major Departments, and directors of contracts in the Ministry of Supply and Ministry of Works. The principal executive officer and senior chief executive officer grades are almost exclusively employed on specialised work in accounts, supply, contracts, finance and technical branches, though a small number of what are known as "executive assistant secretaries" (on the principal executive officer rate) are found, particularly in regional organisations. These posts are thought suitable where there is

* See footnote to Table A.

insufficient policy content in the work to warrant administrative class grading. Chief executive officers and senior executive officers are used on a variety of duties. They may be found within the pyramid of an accounting or financial structure. Alternatively, they may be employed in administrative divisions working to assistant secretaries. It is not always possible to draw a clear-cut distinction between policy work and executive work, so that in many cases the work done by chief and senior executive officers is of the same broad level of responsibility as that of principals. Chief executive officers and senior executive officers are also employed in local or regional offices in a managerial capacity; or may be found giving assistance (say as office managers) to professionally qualified staff in specialised branches of the Service. The higher executive officer is in the same way employed on a variety of duties, but in administrative divisions his task is to give support to principals or chief executive officers, or more rarely, to senior executive officers. The executive officer is similarly employed at the base of the pyramid on all the work indicated above; he is also responsible for the supervision of clerical staff.

The executive class is one of those for which the difficulties of making fair comparisons are greatest. Although broadly comparable work is to be found in many organisations outside, the grading structure of the executive class has no parallel. Even at the lowest level, very few outside employers make the distinction found in the Civil Service between the clerical officer type of recruit and the direct entrant executive officer. Nevertheless some comparison between particular executive grades and grades in industry and commerce can be made."

The Royal Commission considered that in fixing the pay of the executive class considerable account should be taken of relativities with the administrative class and that outside comparisons were to a considerable extent the same for both classes.

It accordingly fixed the pay of the executive grades mainly on internal relativities, using the outside material available as a guide and check.

The Commission were impressed with the high level of responsibility carried by the higher grades and found it disturbing that of the top level executive posts on fixed salaries, only three enjoyed the same salary as an under secretary. The Commission recommended that a review be undertaken and that one of the aspects considered should be the possible application of the principle of broadbanding so as to reduce the number of marginally different rates.

APPENDIX D

SCIENTIFIC OFFICER CLASS

The Scientific Officer Class is the highest of the three scientific classes (the scientific officer, experimental officer and assistant (scientific) classes).

The scientific classes were completely re-organised after the war, following the recommendation of the Barlow Committee which was appointed during the war to review the remuneration and conditions of service of scientists in Government Departments. The Government's proposals arising out of the recommendations of that Committee were published in 1945 as a White Paper (Cmd. 6679). The essential features of these proposals were that better conditions of service should be introduced to facilitate and stimulate research, that the status and remuneration of scientists in the Civil Service should be improved and that a system of centralised recruitment should be introduced. It was recognised that these objectives could only be achieved if a good deal of the work which had previously been carried out by scientific officers, but which did not demand the highest academic qualifications, could be devolved. The White Paper accordingly proposed that the old style assistant class should be re-organised and strengthened and that the title "experimental officer class" would be more appropriate to its new functions. To complete the organisation a new class of assistants (scientific) was subsequently introduced in order to relieve the experimental officer class of the more routine work. The

overall effect of the post-war re-organisation was, therefore, to set up three well defined scientific classes, viz:—

The scientific officer class—recruited primarily from first and second class honours graduates.

The experimental officer class—recruited partly from graduates, but mainly from men and women whose school education had taken them at least to the equivalent of the old style Higher School Certificate with mathematics or a science subject as the principal subject.

The assistant (scientific) class—recruited from those whose education had taken them to at least the level of the old style School Certificate with credit in mathematics or a science subject.

The scientific officer class has the main responsibility for scientific research, design and development carried out in the Civil Service. It is supported by the experimental officer class and the assistant (scientific) class.

Numbers and Pay

The class is composed of the following grades :

<i>Grade</i>	<i>Number of Posts</i>	<i>Pay (Male London Rates) £</i>
Posts above Chief Scientific Officer	23	3,600–6,000
Chief Scientific Officer	43	3,150 or 3,400
Deputy Chief Scientific Officer	128	2,500–2,800
Senior Principal Scientific Officer	418	2,100–2,400
Principal Scientific Officer	1,239	1,450–2,050
Senior Scientific Officer	915	1,190–1,410
Scientific Officer	635	635–1,110
	<u>3,401</u>	

Royal Commission Report

The Royal Commission, in paragraph 544 of their report said:—

“Although we do not recommend any permanent relativity between the scientific officer and the administrative classes, we are impressed by the view of the Barlow Committee (scientific) that the best scientific men should have equal prospects of pay and promotion with the best men in the administrative class at least up to the top of the principal grade. This view was accepted by the Government of the day in 1945 and we find no reason to depart from it now. In the light of the material we have collected about outside rates we believe that the same scale (as for principal in the administrative class) would be fair and reasonable for the principal scientific officer, and should provide a proper reward for the competent scientist who does not proceed beyond that grade. In suggesting that the principal scientific officer scale should for the present continue to be equated with that of the principal we do not of course mean to imply that the equation should be maintained if at any time outside comparisons should indicate that different scales for the two grades would be appropriate.

For the grades above principal scientific officer (and) at the higher levels of the Service (generally) some regard must also be paid to horizontal relativities. The gradings and salaries in the upper reaches of the scientific officer class are not and have never been precisely equated with those of the administrative class, and the secretary of the Department of Scientific and Industrial Research was strongly of the opinion that it would be undesirable to adopt the structure of that class and that the greater degree of flexibility afforded by the larger number of scales and rates on the scientific side should be retained. We endorse

this view and consider that suitable relativities will be achieved if in both classes the grades between principal (or principal scientific officer) and the highest posts are fitted into the span between the maximum of the former grades and the rates for the latter in such a way as to produce proper vertical relativities within each class."

Special Merit Promotion

There are arrangements whereby individual research scientists of outstanding ability can be given special merit promotion above the normal grading of their posts. These promotions are awarded on the advice of a Sub-Committee of the Inter-Departmental Scientific Panel.

APPENDIX E

THE WORKS GROUP OF PROFESSIONAL CLASSES

The term "works group" covers a variety of professions mainly concerned with engineering (in its various forms), building, and estate management and surveying.

It includes architects, maintenance surveyors, quantity surveyors, estate surveyors and land officers, civil, structural and sanitary engineers, and the general service class of mechanical and electrical engineers. These general service classes are provided to cover Departments' professional work in these various fields, and the duties of the classes may be broadly described as including:

- (a) advisory and consultant work for a variety of purposes; decisions on professional aspects of statutory requirements;
- (b) original design and the preparation of complete schemes;
- (c) managerial control and direction of the processes which translate paper schemes into production;
- (d) operation, maintenance and inspection of systems, etc., which have been set up.

The detailed content and organisation necessarily vary from Department to Department, but throughout it is essential that professional staff shall be employed on work which clearly calls for professional handling. All other technical work is devolved to the supporting non-professional classes, in particular, the technical classes and the drawing office (architectural and engineering) classes.

Numbers and Pay

The Works Group Classes include the following grades:

Grade					Number of Posts	Pay (Male London Rates) £
Top Directing Posts	...	...	...	...	29	3,150-5,000
Other Directing Posts	...	...	...	...	137	2,700 or 3,000
Superintending Grade	...	...	...	...	476	2,100-2,400
Senior Grade	...	...	...	...	1,717	1,780-2,050
Main Grade	...	...	...	...	4,450	1,280-1,720
Basic Grade	...	...	...	...	5,865	805-1,250
					12,674	

Notes

(i) The basic grade minimum is tied to age 25. For older officers there is an increase of one increment per year up to age 34.

(ii) There is provision for basic grade officers, both men and women, to have their pay advanced by £75 on satisfaction of three conditions, viz.:—

- (a) they must be at least 27 years of age;

- (b) they must have served a probation period of at least two years and have been confirmed in their established appointment. (Temporary staff also get this increase after two years' satisfactory service);
- (c) they must have attained full professional qualification, which for this purpose is corporate membership of the prescribed professional Institute.

Recruitment

Entry to the works group classes is normally direct, by open competition, taking the form of interview, arranged annually for fully qualified candidates of ages 25 to 35.

Officers of the related sub-professional classes (technical grades and draughtsmen) are eligible for promotion to the Works Group in certain circumstances if they have acquired the professional qualification prescribed.

APPENDIX F

LEGAL CLASS

The legal class is confined to professionally qualified officers (barristers, advocates, solicitors and writers to the Signet) who act as the legal advisers of Departments and conduct their legal business. In some respects this involves professional activities similar to those found in private practice, e.g. giving legal opinions, instructing Counsel, advocacy before the Courts, conveyancing, or the administration of trusts; in others the duties of the class are peculiar to the Government service, e.g. the draftings of statutory instruments.

Numbers and Pay

The legal class is divided into the following grades:—

Grade	Number of Posts	Pay (Male London Rates) £
Procurator General and Treasury Solicitor, ...	1	6,000
Clerk of Crown and permanent secretary to the Lord Chancellor	1	6,000
Heads of legal departments or branches ...	18	Fixed rates from 3,400–5,000
Deputy heads of departments or branches ...	6	Fixed rates from 3,000–4,000
Principal assistant solicitor	6	3,400
Assistant solicitor	92	2,200–2,700
Senior legal assistant	217	1,655*–2,100
Legal assistants:—		
(a) on confirmation of appointment at age 30 }	259	{ 1,140–1,550
(b) during probation (ages 26–30)		{ 875–1,010
	600	

Note

The minimum of the scale of Legal Assistant (on confirmation) is linked to age 30, minus £30 or £35 for each year below that age.

* See footnote to Table A.

Recruitment

Recruitment is almost exclusively by competitive interview to the basic grade of legal assistant. Candidates for posts in the English Departments must be barristers called to the English Bar, or solicitors admitted in England. (For Scottish Departments a candidate must be an admitted advocate or qualified writer to the Signet or solicitor in Scotland.) Candidates must not be less than 26 and not more than 40 years of age. The normal period of probation is one year, and when this has been satisfactorily completed a legal assistant proceeds to the higher scale on confirmation of appointment.

Royal Commission views

The Royal Commission in their Report said:—

"We think that in view of the limited extent to which lawyers are found in graded structures in salaried employment outside the Civil Service, comparison with salaried members of the profession and nothing else cannot be regarded as satisfying the principle of fair comparison. At the same time we do not think that earnings in private practice should be the primary criterion for settling the pay of the class as a whole. The starting rate for recruits to the legal Civil Service should be settled, so far as possible by reference to outside rates and earnings.

For the most part, however, the pay of the legal class must be determined largely on the basis of internal relativities.

We doubt whether even a substantial improvement in the financial attractions offered by the Civil Service would make a great deal of difference to recruitment, in so far as the Service is seeking to recruit young men from the Bar. The conditions of working life in the Civil Service and in private practice are entirely different and the choice of career is likely to be determined by the kind of life for which a man has the taste rather than by financial considerations. The young man at the Bar may have to struggle for some years before he earns enough to keep himself and has to supplement his income by the occasional fees he is able to obtain by lecturing, coaching and writing. Nevertheless even with the assured income, the security and the equitable conditions which it gives, the Civil Service does not always appeal to him. The individual freedom, the excitement and fascination of the life at the Bar are preferred by him and he clings to the ambition and belief that one day he will perhaps figure among the leaders of the profession and attain even to the Bench. It is not disparaging in any wise the great importance and interest of the work of the legal branches of the Civil Service to say that that work has not the appeal which private practice, with all its possibilities and risks and its individual power and influence, has for many men in the profession."

APPENDIX G

MEDICAL OFFICERS

Duties

Medical officers are employed on a wide range of duties which include:—

- (a) The clinical examination of cases similar to those found in medical practice generally;
- (b) the general supervision of the medical aspects of the National Health Service;
- (c) advising on the prevention, control or treatment of industrial, infectious and other diseases and on major health issues;
- (d) health organisation in industrial establishments such as those of the Ministry of Supply;
- (e) the medical (including psychiatric) treatment of prisoners.

Numbers and Pay

<i>Grade</i>	<i>Number of Posts</i>	<i>Pay (London Male and Female Rates)</i> £
Chief Medical Officer (Ministry of Health)	1	5,000
Chief Medical Officer (Department of Health for Scotland)	1	3,750
Chief Medical Officer (Ministry of Pensions and National Insurance, Treasury Medical Service) ...	2	3,750
Deputy Medical Adviser (Ministry of Health) ...	2	3,750
Chief Medical Officer (Colonial Office)	1	3,600
Deputy Chief Medical Officer (Ministry of Pensions and National Insurance, Department of Health for Scotland)	3	3,400
Principal Medical Officer (Ministry of Health) ...	4	3,400
Senior Medical Officer, Senior Commissioner (Board of Control England and Wales)	1	3,400
Chief Inspector—Cruelty to Animals (Home Office)	1	2,700
Principal Medical Officers including the following posts:—	28	3,000
1 Director of Medical Services (Prison Com- mission)		
1 Chief Medical Statistician (General Registrar's Office)		
1 Chief Medical Officer (Ministry of Supply)		
1 Senior Medical Inspector (Ministry of Labour)		
1 Principal Medical Inspector (Ministry of Power)		
2 Medical Senior Commissioners (Board of Control England and Wales)		
Senior Medical Officers	99	2,700
Medical Officers	407	1,825*-2,350
	550	

Note

The minimum of the scale for the medical officer in the basic grade is linked to age 35 and is subject to increase at the rate of one increment for each year above that age up to but not exceeding age 40. It is subject to deduction at the rate of £50 or £55 for each year below the age of 35 (see paragraph below).

Recruitment

Recruitment is usually by competitive interview to the basic grade. The age of entry has rarely been below 32 and more often 35 or over. The lower age limit is 28 years; there is no upper age limit. Occasionally it has been necessary to recruit medical officers from outside the Service to posts above basic grade.

* See footnote to Table A.

Royal Commission Views

The Royal Commission said:—

"While it is reasonable in our view to have some regard to the standards of remuneration of general practitioners and consultants in the National Health Service, we think that the type of work and conditions of employment of the practising doctor differ materially from those of most civil service medical officers. The typical practitioner is commonly drawn to his profession by a sense of vocation for that profession. The pattern of his working life is entirely different from the more equable conditions surrounding the administrative or quasi-administrative duties, important as they are, of medical officers in the Civil Service. There seems therefore to be a considerable element of self-selection at a reasonably mature age among those doctors who decide to enter the Civil Service rather than to serve the community through the exacting but, to many, more satisfying demands of active practice. Considerable weight should be given in settling the remuneration of this class to the standards obtaining for doctors in salaried employment in the more comparable conditions of local government service and in the rapidly growing field of industrial medicine".

Special Merit Promotion

There are arrangements for promoting to the next higher grade a medical officer who carries personal responsibilities substantially heavier than those normally falling to others of his grade and which can only be discharged because of his special knowledge or experience. The promotion is personal to the officer concerned.

ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION MACHINERY FOR REVIEWING PAY IN THE HIGHER CIVIL SERVICE

Memorandum by the Treasury

1. The Staff Side of the Civil Service National Whitley Council have submitted a Memorandum on this subject. Since this Memorandum deals at length in Part I with the Staff Side's submissions to the Priestley Commission, the Treasury think that the Royal Commission on Doctors' and Dentists' Remuneration may wish to have a fuller account of the Treasury's submissions on the same subject.

2. At the second day's hearing Treasury witnesses were questioned (Questions 248 to 250) on the case for consenting to arbitration above the compulsory arbitrable limit. At the Priestley Commission's request the Treasury put in a paper, reproduced in Appendix I to the Minutes of Evidence—submitted to the Priestley Commission. This paper is annexed to this memorandum. It recites the history of arbitration arrangements in the Civil Service and of the arbitration limit, and goes on to say:—

"Successive Governments have always taken the view that posts at managerial level should not be subject to compulsory arbitration. Senior civil servants occupy a delicate position as Advisers to Ministers on all questions of Government policy. And it would not be right or appropriate that persons who occupy this position and are engaged on these duties should have the right to take the Government to compulsory arbitration.

The next question is where the line should be drawn. In the Treasury view it is right to draw the line as at present so as to exclude from compulsory arbitration Assistant Secretaries and grades on similar salaries in the other Classes. At this point a marked change takes place in the nature of the responsibilities carried."

3. When Treasury witnesses were examined again on the 21st day Sir Edward (now Lord) Bridges (Questions 3185 to 3195) put forward his personal suggestion that there should be a Standing Advisory body to *advise* the Government on the pay of the Higher Civil Service, that the Staff Side should not be formally consulted about its membership and that only the Government should have the right to set it in motion.

4. In Part I of the Staff Side's submission there is also a reference in paragraphs 7 to 10 to a number of occasions in which special arrangements have been made to resolve differences of opinion between the Official and Staff Sides about the remuneration of Higher Civil Servants. The Treasury wishes to make two observations:—

- (a) Sir Alexander Gray's role in the matter referred to in paragraph 9 was described as that of umpire and the proceedings as "informal arbitration". His report put forward what he described as his "opinion" and it was accepted by the Treasury.
- (b) The investigations by the Chorley and Gardiner Committees did not constitute arbitration. The Committee tendered advice which the Government were free to accept or reject. The same is true of the Standing Advisory Committee on the Higher Civil Service under the Chairmanship of Lord Coleraine appointed on the recommendation of the Priestley Commission.

ROYAL COMMISSION ON THE CIVIL SERVICE CIVIL SERVICE ARBITRATION AGREEMENTS: SALARY LIMITS

Note by the Treasury

1. During the 1914-18 war, a Conciliation and Arbitration Board for Government Employees was set up to deal, by way of conciliation or arbitration, with claims for increased remuneration made by non-industrial civil servants. This Board was, however, precluded by its terms of reference from entertaining applications for permanent increases in salary (i.e. as distinct from temporary increases due to war

conditions) from the more highly paid classes of employees. The classes so excluded were those with fixed salaries of £500 or more, or scales with *maxima* of £500 or more (excluding bonus in each case).

2. The Board was abolished in 1922, but in 1923 the Government agreed in principle that Civil Servants should be entitled as of right to take pay claims to arbitration, the outcome of which the Government would regard as binding; and a Committee of the National Whitley Council was appointed to frame a suitable scheme. (The right so conceded has come to be known in Civil Service parlance as the right of "compulsory arbitration".) Negotiations were prolonged, and one of the points in dispute was the fixing of a salary limit above which the right of compulsory arbitration would not be conceded. Agreement was eventually recorded in 1925, and this was the first of the series of arbitration agreements on which the present machinery depends. The agreement resulted in a field for compulsory arbitration substantially wider in a number of respects than the field covered by the war-time Conciliation and Arbitration Board, in particular as regards the limits of salary. Compulsory arbitration was excluded in the case of classes with fixed salaries in excess of £700 basic and salary with *minima* of £700 basic or more, but it was provided that claims in respect of classes above these limits could be submitted to arbitration with the consent of both parties. (This is known as "voluntary arbitration".) In the negotiations leading up to this agreement, the Official Side had in mind that the salary limits would exclude from compulsory arbitration the controlling or managerial grades. Under this agreement there was still excluded from compulsory arbitration the grade of Administrative Principal, whose scale at that time was £700-£900 basic.

3. The Royal Commission on the Civil Service (1929-31), whose terms of reference invited them to consider "the machinery for the discussion and settlement of questions relating to conditions of service", recommended that the limit should be changed so as to allow compulsory arbitration to classes with fixed salaries not exceeding £1,000 a year consolidated or salary scales with *maxima* not exceeding £1,000 a year consolidated. This recommendation, if adopted, would still have excluded from compulsory arbitration the grade of Administrative Principal, for which the Tomlin Commission recommended a salary scale of £800-£1,100 consolidated.

4. The recommendation was, however, not adopted. One difficulty was that it would have excluded from arbitration some grades previously eligible for it. After prolonged discussion, it was agreed in 1939 to adhere to the previous basis of determining the limit by reference to the *minimum* of the scale of the grade, but to substitute £850 consolidated for £700 basic. One effect of this decision was to include the grade of Administrative Principal within the field of compulsory arbitration for the first time.

5. The limit was reviewed when post-war consolidated salaries were determined. After negotiation it was agreed in 1947 that the limit should be related primarily to the *maximum* of the scale, but regard should be had to the minimum also. The effect of this agreement was to exclude from arbitration, except with the consent of both sides, any grades on—

- (a) fixed salaries exceeding £1,300;
- (b) scales with *both* a maximum above £1,300 and a minimum of £1,150 or more.

This agreement was subject to an understanding that—

- (i) the limit would be looked at again in the light of any increases which might be awarded on an Executive class salary claim then pending;
- (ii) it would be the disposition of the Treasury to agree to voluntary arbitration above the limit wherever they could, and
- (iii) they would especially be so disposed on any occasion where arbitration proceedings in respect of grades below the limit would be hampered for the parties or for the Tribunal, unless a closely associated grade above the limit was also within the scope of the proceedings.

6. In 1951 the limits were raised to take account of pay increases so as to substitute £1,450 for £1,300 and "above £1,200" for "£1,150 or more" in the 1947 agreement.

7. A limit above which claims may not go to arbitration without the consent of both parties has therefore been a consistent feature throughout, though the salary figure has been revised from time to time, primarily to take account of salary increases.

8. Successive Governments have always taken the view that posts at managerial level should not be subject to compulsory arbitration. Senior civil servants occupy a delicate position as advisers to Ministers on all questions of Government policy. And it would not be right or appropriate that persons who occupy this position and are engaged on these duties should have the right to take the Government to compulsory arbitration.

9. The next question is where the line should be drawn. In the Treasury view it is right to draw the line, as at present, so as to exclude from compulsory arbitration Assistant Secretaries and grades on similar salaries in the other classes. At this point a marked change takes place in the nature of the responsibilities carried. To take the Administrative Class as an example, the Principal grade, though it carries considerable responsibilities and often makes a contribution to many matters of high importance, is engaged mainly on the "bread and butter" work of an administrative Division or Branch. The Assistant Secretary, on the other hand, is usually responsible for the general management of a Division or Branch, and is often concerned with matters of high policy, sometimes in direct contact with Ministers. For these reasons, the Treasury consider that the Assistant Secretary grade is essentially a part of the managerial element of Government, with status and responsibilities sufficiently high to justify its being placed above the line which divides the broad mass of the Service, with its right to compulsory arbitration, from the highest grades, which require special treatment. The recommendation of the Tomlin Commission on this point, referred to in paragraph 3 above, is consistent with this view, and, in the Treasury's submission, it would not be justifiable to draw the line to-day above the Assistant Secretary grade, unless it were to be established that the duties and responsibilities of that grade are now markedly lower than they have been in the past.

10. These arguments do not apply in the same degree to grades in other classes parallel with the Assistant Secretary grade, but it seems to the Treasury only sensible to deal with this matter by reference to salary levels, and therefore to draw the line at the same point in the salary structure of all classes.

11. But although the Government decline to give a right of compulsory arbitration to the higher grades of the Service, that does not mean that they are unwilling ever to submit the question of their remuneration to the independent judgment of a third party. On the contrary, they do so freely. The submission to the present Royal Commission is only the latest example of a large number of similar references—for instance, the Chorley, Gardiner and Howitt Committees, to name only post-war examples.

12. The formal differences between such references as these and a right to compulsory arbitration are, first, that the initiative in instituting the enquiry rests with the Government, not the staff; and second, that the Government do not bind themselves in advance to accept any recommendations which may emerge. But there is a perhaps more important difference. In determining the salaries of the higher Civil Service, wider and less tangible considerations have to be taken into account than fall to be considered by the Arbitration Tribunal in the ordinary run of salary claims. And a Commission or Committee which can summon witnesses and collect evidence on its own initiative, of a kind not always available to parties engaged in negotiations and arbitration, is much better equipped to conduct a comprehensive enquiry and reach a correspondingly authoritative conclusion.

13. It is true that enquiries of this sort take some time and are not very frequent; but, for the reasons given in earlier evidence, the Treasury hold that very frequent reviews of the salaries of higher civil servants would be undesirable. And they consider that, provided the Government are always willing to appoint an authoritative body whenever there is real cause to believe that a review should be undertaken, the higher grades of the Service will be assured of fair treatment and would not themselves wish to press for compulsory arbitration.

Cases above the arbitrable limit which have been allowed to go to arbitration

14. Claims in respect of classes and grades whose salaries are outside the arbitrable limits are not allowed to go to arbitration "except with the consent of both parties". In considering whether their consent should be given, the Official Side have had regard to the understanding reached with the Staff Side towards the end of 1947 (see paragraph 5 above).

15. A list of the claims which, since 1948, have been allowed to go to arbitration, despite the fact that they were outside the limits, is given in the Annexure to this paper.

ANNEXURE

Compulsory Arbitration Limit	Award	Date	Grade	Salary
Flat Rate: £1,300 Scale: both minimum-£1,150 or over and maximum above £1,300	96	July, 1948	Keeper Deputy Keeper [National Gallery]	£1,320-£1,520 £1,160-£1,320
Flat Rate: £1,300 Scale: both minimum-£1,150 or over and maximum above £1,300	123	July, 1950	Superintending Inspectors [Ministry of Labour]	£1,250-£1,450
Flat Rate: £1,300 Scale: both minimum-£1,150 or over and maximum above £1,300	127	July, 1950	Deputy Keepers [P.R.O.]	£1,160-£1,320
Flat Rate: £1,300 Scale: both minimum-£1,150 or over and maximum above £1,300	132	December, 1950	Conservator [Forestry Commission]	£1,275-£1,425
Flat Rate: £1,300 Scale: both minimum-£1,150 or over and maximum above £1,300	172	December, 1951	Director of Communications [Home Office]	£1,160-£1,370
Flat Rate: £1,450 Scale: both minimum above £1,200 and maximum above £1,450	186	April, 1952	Dental Officers	£1,250-£1,550
Flat Rate: £1,450 Scale: both minimum above £1,200 and maximum above £1,450	214	February, 1953	Principal Officers Deputy Chief Consultative Officers [Ministry of Transport]	£1,350-£1,550
Flat Rate: £1,450 Scale: both minimum above £1,200 and maximum above £1,450	225	July, 1953	Principal Examiners [Board of Trade]	£1,250-£1,500

Examination of Witnesses

SIR THOMAS PADMORE

MR. A. J. D. WINNIFRITH

on behalf of H.M. Treasury.

SIR JOHN HAWTON

DAME ENID RUSSELL-SMITH

MR. D. A. V. ALLEN

on behalf of the Ministry of Health.

MR. J. ANDERSON

MR. N. W. GRAHAM

on behalf of the Department of Health for Scotland.

MR. J. L. NICHOLSON

on behalf of the Central Statistical Office.

Called and Examined

3463. *Chairman*: Sir John, I would like to start by thanking you for the amount of trouble that has been taken first of all in preparing the factual memorandum which we got last July, after what seemed to have been some delay; it has been well worth waiting for. It has really not been challenged as to facts so far and it has been extremely useful throughout. I would also like to thank you for the trouble you have taken in preparing this detailed volume of replies to the questions that we sent out to you in the fairly early stages of our enquiry when we had not quite focused—as we now have—on some of the more important issues. However this covers a good many of them. I understand that you would prefer us to stick to the order of the topics, broadly speaking, with certain exceptions to suit the statistical experts whom we propose to take this afternoon, as a matter of convenience to both sides. But if we do this we shall probably want to switch about a bit from one topic to another, and then at the end we may wish to go back and ask more questions about any point which we may have missed in this way. That would suit you best, would it?—*Sir John Hawton*: Yes, we are entirely in your hands.

3464. Thank you very much. I think on previous occasions I have explained to others who have come before us that if we appear to press them fairly thoroughly on the points they have put to us it does not mean necessarily that we do not believe them or that we are hostile, and equally if we do not follow

up all the points which have been mentioned it does not mean that we necessarily accept that point of view. I think I should say the same thing to the Government, although no doubt you are aware of it already.—Yes, we quite understand.—*Sir Thomas Padmore*: I wonder if, before we begin on the business of the day, I might say a word about two general points which I think are relevant to what you have just said about the way in which the Commission proposes to proceed. The first point I wanted to mention relates to the position of the Departmental witnesses who are before you now. I would say this, primarily on behalf of my Treasury colleague and myself—and I think it also goes for my colleagues from other Departments—that we do not suppose it to be the wish of the Commission or our duty, in what we shall say in evidence, despite the fact that we speak as it were on behalf of and as representing the Government—we do not conceive it to be our duty to attempt to adopt an attitude of complete neutrality on all the questions that we shall be considering.

3465. Certainly.—It seems to us that there are things here, as in any other walk of life, to be said on both sides. There are arguments and contentions that can be advanced, and have been advanced, in favour of the interests of the medical and dental professions, and there are also things to be said on the other side. Because the representatives of those professions are in no need of assistance from us as regards the first category of evidence, we have supposed

that it would be the wish of the Commission that we should address ourselves primarily to putting before you the contrary contentions, since it is obviously right that the Government—on behalf, if you like, of the taxpayer who stands behind the Government—should take this opportunity of stressing primarily the contentions that I have mentioned, those that are contrary to those contentions which are made on behalf of and in favour of the two professions. But although that is the general line that we had supposed it would be the desire of the Commission that we should take, I would like to say that we should none of us like it to be thought on this account that anything we may say implies, either in the Government itself or in the Departments, that there is any desire to see anything but an entirely fair and just settlement arising from the work of this Commission; or still less that there is any kind of hostility in those places towards these two great professions and towards the National Health Service. It is simply that, on the assumption that the path of wisdom may—as it so often does—lie between contentions that may be advanced on either side, we conceived it our duty in the main to put forward what might be called the reverse side of the medal rather than the side that has been and is being presented by the professions and the Service. If I may say so, we supposed it to be the duty of the Commission rather than our own to weigh the arguments one against the other and to find a fair solution. I am sorry to have taken so long about this, and no doubt it is all very obvious; but I wanted to ask your permission to get it on the record lest our principles and what we might say might be misunderstood. The other thing is simply that the Treasury appears here this morning happily in a quite secondary role. Anything that has directly to do with the members of the medical and dental professions in the National Health Service is primarily the business of the Health Departments; and in all those matters, with your permission, they will take the lead. The Treasury will give any help it can and we will, again with your permission, take the lead on those questions affecting such other Departments as are outside the Ministry of Health.

3466. Thank you, Sir Thomas. I think I can say that the Commission were very glad to see that in many of the papers

there was no weak neutrality; quite definite points of view, into which we could get our teeth, have been put forward, and we appreciate that. Also we appreciate the point as regards the fact that the Treasury speak on some subjects and the Departments on others.

Sir John, it would seem to us that a generally satisfied profession as a whole must be one of the most important things of all. Would you feel that that is so—that there must be confidence between the professions and the Government?—*Sir John Hawton*: I should have thought that was the most important thing possible, if it is achieved on a fair basis.

3467. Would you think it would be possible to have confidence if there was not a fair basis?—*On one side, no.*

3468. And was that to some extent the intention or the hope that arose from the appointment of the Spens Committees—that there should be established conditions that would lead to permanent satisfaction in the Health Service between the profession and the Government?—*It was certainly the hope, but it would not be fair to say that the whole purpose of establishing the Spens Committees was simply that. That was the hope, that that would be the result, but as regards the purpose I think it might be put more simply in this way. There has been so much confusion. I think, between the profession and ourselves—I am attributing no blame to either side—as regards the position of the Spens Reports and the Danckwerts Award that I think it is worth trying to get it down to fundamentals. The point is that we were starting in 1948 a service which had never existed before, and of a kind which had never existed before. We knew, in spite of some things which were said, that the bulk of the professions with which we were concerned would in fact be affected by it and would, to varying degrees, take part in it. Our problem therefore was to find some guidance as to the fair terms to offer on which their participation could be based. So we appointed independent committees, the Spens Committees, in order to advise on this matter. They, as you know, advised us first what they thought would have been fair in 1939 by adjusting what in fact was the position in 1939, and then they said*

—and this perhaps has been the bone of contention—"We leave it to others"—presumably meaning the Government—"to decide what alteration from 1939, as adjusted to the post-war conditions of service of 1948, should be the proper betterment factor".

3469. You say presumably meaning the Government. That is so, is it?—I should qualify that—the Government, presumably in consultation with the professions; that is to say, the Government, being the paymasters, presumably with the professions in consultation, have to settle it. The point I am making is that the Spens Committees did not settle it; and that is to my mind the root of a lot of our troubles. Putting it as shortly as I can, the problem since then has been a disagreement as to the amount of betterment. This problem, in the case of the general medical practitioners, went on so long that it was agreed to refer it to an adjudicator to see who was right and what the amount of betterment should be. That is your Danckwerts Award. The parallel to that is a negotiated settlement with the general dental practitioners. The Government had asked, in starting the Service, for advice as to how to start it fairly. They were told they had not started it fairly. They went on trying to get a settlement and eventually referred to adjudication on the one hand and a Whitley agreement on the other. That is the Government's final position. They regard that, from the point of view of the Spens Committees and the Danckwerts Award, as a perfectly normal commonsense arrangement which has achieved its purpose. Now the question arises as to whether, quite apart from that, there should be any further adjustment; there is a claim from the professions for this. And because on the one side the profession bases everything on the notion that Spens, with Danckwerts, should continue for all time to govern professional income—a sort of continuous insulation against the friction of life which other professions do not enjoy—because of that it was decided that the only rational, or shall I say radical, thing to do was to say, "Let us look at this right from the ground up. We will go on bickering for ages—let us look at this and have a complete and unbiased enquiry into the whole situation, particularly in relation to what is happening in other

comparable employments". And that was the origin, as you know, Sir, of this Royal Commission. I just wanted to say that, because there is so much travesty of the position of Spens and I wanted to get that on to the record.

3470. Thank you. Now we will go back to Spens for a bit. Can you say why there were three Spens Committees instead of one—because they did produce reports on rather different principles, and the subsequent application of the "leaving to others" was dealt with differently in the three cases?—The three committees had a common chairman but different memberships, judged to suit the subjects with which they were dealing. We did not think at that time that one committee would be suitable for all those subjects—the general medical practitioner, the consultant and the dental practitioner; but we thought the common factor of a common chairman would correct any divergence.

3471. Looking back on it, would you think that was wise?—I think it was wise to have a common chairman.

3472. Yes, I was not referring to that quite so much—I meant to have different reports and different interpretations thereafter.—I think it was wise to have committees suitably constituted for the different subjects, yes.

3473. Yes. Now coming to the report on general medical practitioners' remuneration, which was the first one, was it not?—Yes.

3474. That would seem to have been to a considerable extent a report on distribution.—No, it included recommendations on distribution, but its purpose was the purpose I tried to describe just now.

3475. It made seven recommendations, I think.—Yes, it made one on distribution, which I think has not been able to be carried out under the present system of the central pool and which, as far as I know, we have not been asked by the profession to carry out, because it is inconsistent with the idea of paying out of a pool.

3476. The Committee did in fact make seven recommendations, of which I think virtually six are primarily concerned with distribution, are they not?—I would like Dame Enid to answer this point. I hope it is all right for the members of

the Commission if one or other of our members answers their questions on certain subjects?

3477. I should have said to you, Sir John, that from this side you are liable to receive questions from any quarter, and we expect any of you at all to feel free to be prepared to join in. While I am primarily addressing my questions to you, as being the focus of it all, I would like any of your colleagues to feel free to answer questions at any time.—Thank you, I am very glad of that and I am quite sure that my colleagues will be able to assist you more than I can.—*Dame Enid Russell-Smith*: In sub-paragraph 3 of their recommendations the Spens Committee, Sir, say that the method of differentiation of income chosen should command as far as possible the confidence of the profession. The profession were accustomed, under the old Insurance scheme which preceded the National Health Service, to the capitation system of remuneration. It was one which in general commanded their confidence and one to which they attached very great importance. The capitation method was found to be incompatible with the degree of control which would be needed to secure the precise type of spread of incomes which the Spens Committee originally had in mind, so in adopting that method we found we had ruled out the more precise control of distribution which is contemplated in sub-paragraph 1 of the recommendations.

3478. Those recommendations on page 12 of the Report are really almost all to do with distribution, are they not?—Yes.

3479. And Spens was set up to try and secure a particular spread of incomes among the general practitioners.—He did recommend a spread but, as I have tried to explain, it was found that if we adopted the capitation method of payment, which was the method of choice of the profession and one which had been tried out over many years in the Insurance scheme and tested—that could not be maintained with the degree of control which would have been needed to secure precisely this spread of incomes in Spens. The Commission have asked for figures, which we hope shortly to be putting before them, and these figures will illustrate what has actually happened in practice, and it will then be possible to

compare what has happened in practice with the sort of spread of incomes which the Spens Committee contemplated.—*Sir John Hawton*: You say that the purpose of Spens was in connection with distribution. If you look at the terms of reference of Spens, of course, that is not mentioned.

3480. No; it is what ought to be the range of total professional income, with due regard to the normal professional income in the past etc.—I tried to explain the object earlier.

3481. *Professor Jewkes*: Suppose when we get the additional figures it is proved that the distribution of earnings was very different from that which had been contemplated by Spens, would you regard that as a serious weakness in the present system to which we ought to turn our minds?—*Dame Enid Russell-Smith*: If I may say so, I think that if that information was likely to show a very wide difference from this sort of spread, we would have heard of it before and we would have done something about it. While I do not think that the figures will show the same spread as Spens recommended, I do not think it at all probable that the difference will be very great.—*Sir John Hawton*: May I add on that that we could not, I think, feel that the fact that it differs from the Spens idea of distribution was an all-governing factor. We should much rather, if we had to have advice on that, have the advice of this Commission.

3482. *Chairman*: So that is another matter on which you consider that Spens was a means of starting off the Service but not of continuing it forever?—We cannot accept this apparent contention that there is some mystique about the Spens Reports for all time.

3483. At what stage would you think that the profession as a whole, not merely the leaders of the profession but the profession as a whole, should have realised that you viewed the Spens Report purely as starting off the Service rather than as providing a permanent and rather precise framework?—We have, I think, answered that at some length in Appendices I and II of our memorandum, where we give you the statements made from time to time by Ministers, the Chancellor and others, making that abundantly clear; but in fairness I would say at no time has it been accepted by the profession as far as I know.

3484. The first of those statements really was in July, 1946, when the scheme as a whole was pretty certain to come into operation?—Yes.

3485. And do you know if any steps were taken then beyond that statement to make the Government's view abundantly clear to the profession as a whole?—Perhaps Dame Enid would answer on the historical part of that paper?—*Dame Enid Russell-Smith*: I would say, Sir, that it had not originally occurred to us that the interpretation which we later understood the profession placed on this Report—that is that the remuneration should, as we understand it is the contention, be tied to the cost of living, was a feasible one to put on this Report. The early discussions with the profession related to changes in the numbers of doctors required to provide a service, which was a point in dispute up to the time of the Danckwerts award. The change in the cost of living was also mentioned but at that stage it appears to have been a subsidiary point. It was only over a period of time that it became apparent that the profession interpreted this Report as tying their remuneration to changes in the cost of living. The reason why it had not occurred to us that that interpretation really could be held was that it did import a unique principle in respect of professional remuneration, and it seems almost inconceivable that if the Spens Committee had intended to recommend so great a departure in respect of the medical profession that they would not have said a word about it in the summary of recommendations at the end of the Report, to which you have just referred and which do constitute their recommendations.

3486. *Mr. Gunlake*: And if the Ministry did not contemplate that the Spens Report had anything to do with possible remuneration in later years, what machinery did they contemplate?—*Sir John Hawton*: The ordinary process of negotiation.

3487. Was that made clear to the profession? Could you describe that machinery?—Yes. I think you perhaps already have the information. There is a reference in the note we gave you. It is in paragraph 3 of the memorandum. We make the position clear there, and we quote the Departmental record we have of a meeting when the members of the profession did ask for an assurance

that the central pool would be continuously adjusted to maintain in the future the levels of remuneration recommended in the Spens Report. The representatives were informed that the Government's acceptance of the Report was at a particular time and that the British Medical Association could not properly plead that, whatever changes occurred in the volume of work or the economic state of the country or any other factors, the profession would for an indefinite time receive remuneration based on the Spens Report. That is our record of a talk in December, 1949.

3488. *Chairman*: It was some time after the Service had started, and by which time the profession was well and truly in it, for better or worse?—Of course, as Dame Enid said, it only emerged slowly that they were taking this view. In fact the Government's view was given in answer to a request—it was a considered view.

3489. *Mr. Gunlake*: I notice that in a letter written in July, 1946, on behalf of the Ministry of Health, which appears in Appendix I, it is stated that the Minister, "accepts the substance of the recommendations of the Committee—that is, of course, the Spens Committee—in their majority report upon the general scope and range of remuneration which general practitioners should enjoy in a public service"—it does not say the scope and range that they should enjoy upon entering the public service.—No, it never occurred to us that anyone would take the view, which I should have thought—this is a personal opinion, of course—was a little extraordinary, in that when you have asked somebody to recommend what should be a rate for people coming into a public service and that is accepted, that that is taken to be an acceptance for all time, shall we say a hundred years, irrespective of the condition of the country or any other factors. I do not think any government could accept that.

3490. But was this question ever gone into? Here was a question which, as you yourself have said, concerned an entirely new service in which you had to have the co-operation of the medical and dental practitioners. They were necessary for it. Therefore they had to be taken into consultation and an agreement made with them. Surely it must have occurred to them to look to the

future and think not merely of the terms upon which they entered the Service but of the basis upon which things should be reconsidered from time to time—was that never discussed? Were the medical profession not interested in what happened to them after the appointed day?—They seem to have been extremely interested; and indeed in making their claim they regard the Spens Report and the Danckwerts Award as the criterion for ever. What I was trying to say was that that is a view that no government of whatever conviction could possibly accept for one profession in isolation.—*Dame Enid Russell-Smith*: Could I add that as regards the machinery, we were proposing to set up a series of Whitley Councils which would be the future machinery of negotiation, and the profession were, of course, acquainted with the machinery which had prevailed under the old Insurance scheme when the capitation fee was adjusted from time to time in negotiation.—*Sir John Hawton*: I would like again to try and simplify this, if I may. Everyone would normally think that as circumstances altered there would be negotiations for altering the remuneration. That applies not merely to these two professions we are discussing but to everyone. Of course that is so. The point I am trying to make is that it could not be expected that a particular report or document should be an absolutely sacrosanct yardstick—if that is not mixing a metaphor—by which the thing is automatically judged and therefore negotiation is hardly necessary.

3491. *Chairman*: Yes, I think that while we may be willing to accept that, Sir John, the question really is when did the profession, who were changing over from being comparatively independent to being much more in the hands of a monopoly employer as it were—when did they realise that? Because there have certainly been some misunderstandings on this point. I do not think there can be any doubt that many doctors have believed that they were insured, perhaps not absolutely for ever but at any rate for quite a time, by something pretty permanent.—If you say when did they realise it, of course I cannot answer. I can only say they were never in any way misled by the Government side; and indeed it was always contemplated that there would be, as it were,

negotiating machinery under Whitley. When it was discovered that they were taking that line, then a number of corrections to that view were given, which we have set out.

3492. *Mr. Bonham-Carter*: Sir John, in the Spens Report in paragraph 6—I am sure this is a paragraph which must be well known to you—there is a final sentence which says, "In our judgment, it is only if corresponding changes are made in the incomes of general practitioners that the recruitment and status of their profession will be maintained as against these professions". That might have in it a view looking towards the future, because it talks about recruitment. Would it be the view of the Ministry that that was again only related to the immediate position?—No, in our view that would be an expression of principle in answer to their terms of reference as to the method. I would draw your attention to the sentence immediately preceding, in which they say that the adjustment should have direct regard not only to changes in the value of money but to increases which have taken place in other professions. In other words they themselves bring in that factor as a corrective factor.

3493. *Sir Hugh Watson*: While on the terms of reference, Sir John, we know that Spens said he left it to others to determine what the remuneration was to be at present. He used the words "at present", as you very well remember; but his remit was to determine the remuneration of the medical profession having in view the desirability of maintaining in the future the proper social and economic status of general medical practitioners. There is no doubt that Spens was set up—at least it humbly appears to me—to consider what would be the remuneration which would attract doctors in the future.—I should have thought that meant and it was intended to mean that Spens was set up on the footing that we have no information of such a service in the past and we want to know for the future what kind of proper basis should be adopted—and he did that and fulfilled his duty. I do not think—of course I cannot speak for Sir Will Spens himself—but I do not think he would imagine he was set up as a sort of permanent yardstick which really prohibited negotiation, in that you only had to measure against the formula of Spens.

3494. *Chairman*: There would seem, Sir John, to be a bit of difference between just one point in time in 1948 on the one hand and absolute eternity on the other hand; and it would seem that the profession was at least justified in thinking that this was a starting point that would carry them through at least for some years until experience had shown that modifications were needed in the methods of distribution and so forth.

—I think they would have been perfectly justified in thinking that this was the starting point which had been asked for, and that after that no doubt there will be need for adjustment and there will be negotiating machinery to secure it—not that there will be no need for negotiating on all factors but merely to look at the Spens Report and do a sum.

3495. We will come to that later, but you will agree that they had justification not really for regarding it as once and for all but that it had at least some bearing on the future.—I think the main justification would be to think that there must be machinery for adjustment in future. I am not suggesting that the Spens Report has no significance at all even now—of course not. Every document of any committee which has examined these subjects must be a relevant document, but it is not a final and authoritative and sole document.

3496. I think the point I am trying to make is that the other side, as it were, the doctors, ought to have known without any doubt the kind of interpretation that would be put on it. Do you feel that these statements succeeded in making that clear, the statements you have given us in the appendices?—We always have felt that we tried to make that clear as soon as we realised that that view was entertained by them. I agree we have not succeeded in making it clear to all.

3497. If you take extract No. 1 that you quote in your Appendix I about the general medical practitioner report, I do not see that that particularly makes this point about a point of time rather than forever. It says that the actual terms of remuneration cannot be calculated by a simple process of arithmetic but involves a number of factors, e.g., superannuation and a percentage of betterment. It does not really go out of its way to say that this is a basis for entering into the Service and that afterwards will be another matter.—But

we had no reason at the very beginning to know that this interpretation of the application of Spens was adopted. When they asked us late in 1949 whether that was the position we gave them a very clear answer.

3498. *Sir Hugh Watson*: We are trying to get to the bottom of these misunderstandings, as you see. In their case the British Medical Association quoted to us a letter dated 2nd May, 1950, from the Permanent Secretary to the Ministry of Health in which this sentence occurs, "The Minister agrees that the Spens Report remains the basis of remuneration of general medical practitioners until such time as, after the usual consultations, some other basis is substituted". Is that in fact the position of the Ministry?—It is the position, of course, that until negotiations had succeeded in doing something better, at that time we were leaning on Spens for the time being.

3499. And for how long was "the time being" going to last?—Very little time, because we believe the right thing with any profession is to take every fact into consideration.

3500. *Professor Jewkes*: As regards the various adjustments that it was thought might have to be made after 1948, is it a fact that in 1948 everybody assumed—and certainly the Ministry assumed—that the various Whitley Committees were going to become really active and that they in fact would play an important part in bringing about these adjustments?—We wanted the Whitley system to be active, but I am not suggesting that there is anything particularly wrong in effect in the difference between a Whitley Council for general practitioners and a direct negotiation with them. The management side would presumably mean the Ministry in another guise, and so I am not suggesting there is any terrible fault in that. What I am trying to say is the simple thing that there is nothing unique about the situation of these professions. In other words they are in the position that everyone else is, or should be, and that if they have a just claim for increased remuneration they should discuss it and every factor should be taken into account and agreed if possible. It is because we have consistently failed to convert them to that view that we thought it was the fairest thing to all concerned to have this Commission.

3501. And I suppose in 1948 everybody—all of us—was foolish enough to imagine that prices were not going to change very much in the future and that therefore adjustments would not probably have to be very large?—I think perhaps the Treasury know more about that than I do.—*Sir Thomas Padmore*: I think that is very true.

3502. *Mr. Gunlake*: And in any case you think the profession's interpretation is a "travesty"—your own word, I think.—*Sir John Hawton*: Yes, I think that if it were universally applied to other professions and occupations it would produce an impossible situation.

3503. *Chairman*: But it is not merely the British Medical Association that appears to have had a feeling that the Government were not quite to be relied on in these matters—that they did not know where they stood. Is that not true?—I am wondering who else you are thinking of.

3504. Well, the British Medical Association does not perhaps speak for all the doctors. We have met the British Dental Association and the Joint Consultants Committee, and we have had some fairly general evidence to this effect.—When I talk of the profession I never identify them entirely and exclusively with the British Medical Association, of course.

3505. No. We have had one point put to us, I think only from one quarter—and certainly an important one—and that was on this question of leaving it to others. It was suggested that the meaning of those words was that the doctors should get either an increase representing the change in the value of money or changes in other comparable professions, whichever was the bigger. Have you any views upon that particular point?—I cannot find any justification anywhere for interpolating the phrase, "whichever is the bigger".

Chairman: No, I did not think you would support that view. We have had it put to us from one quarter.

3506. *Mr. Bonham-Carter*: Sir John, I think I remember the time this question was asked, and it is related to the words, "should have direct regard"—that led into this statement, I think, which the Chairman has just repeated.—But surely one must finish the

sentence—to have direct regard to two things—not only (a) but also (b).

3507. *Mr. Gunlake*: Do you feel then that what should be taken is, "whichever is the lower"?—No, I think that what should be taken is all the factors, and particularly the relationship of this particular profession which, after all, is not—with the greatest respect—unique, to other learned professions and the position of other occupations. In other words not to take this profession in complete isolation as though its members were something not as other men.

3508. *Chairman*: Now, Sir John, in paragraph 7 you say that the Government consider that the primary consideration to be taken into account in contemporary circumstances is the level of remuneration now received by members of comparable professions. Have you been trying to pursue that line of comparable professions yourselves during the last few years and trying to ascertain what the members of comparable professions were earning?—We never really got to a position of negotiation in which one could get as far as that. That is, if I may say so again, the reason for this independent inquiry; and also our view might be suspect, quite rightly, because we might be suspected of having an interest in selecting the comparable professions. Indeed the whole point comes back time after time to the fact that there is an absolute deadlock on the idea of the validity of Spens.

3509. *Professor Jewkes*: If in fact it was clear to both sides that a comparison would have to be made between the medical profession and other professions, clearly some evidence would have to exist about the earnings in other professions, and so far as we have gone I understand that information does not really exist. Is that true?—We have never got as far as collecting it, largely because, as far as I can remember, that has never been accepted in talks with the profession as being particularly relevant. We have always come back to this doctrine, "Here is the book—the Spens Reports—and this is what you go by."—*Mr. Winnifrith*: Could I say something here? I believe that there is quite a lot of evidence about what people are being paid in professions which you might think were comparable. There is nothing satisfactory in the way of overall figures,

but there is a lot of information about what people are getting at various levels in other professions.

3510. *Sir Hugh Watson*: Professor Jewkes' point is that nobody has apparently sat down to make a definite comparison.—No.

3511. I know there is a lot of talk about it, but nobody has ever sat down and worked out a definite comparison. Spens directed attention to be had to two things. We know the first one. There are tables and statistics of all kinds, but nobody has ever said, "Let us enquire into the second one and produce some sort of *modus vivendi* for it."—I quite agree. All I was saying was that if anyone wanted it, there is a fair amount of material available.

3512. *Chairman*: But would it give the full spread of incomes within a profession?—I am sure it would not produce what the profession as a whole was getting. What you would find would be what people were getting at various points in their careers—samples or averages of what they were getting at various points in a career.

3513. You see, the Danckwerts Award was made in 1951 and from then until 1957 there was no change in the remuneration of general medical practitioners at all. Now do you know of any other profession containing people earning from, say, £1,000 to say £4,000—just as an example—where that condition applies?—*Sir John Hawton*: Perhaps the Treasury will tell you whether they know of any other profession, but I would first make one comment. I think it is not fair simply to say that since 1951 there has been no change. It is much fairer to say what is the relative position between now and before the war, as a result of what changes there have been—to take 100 per cent. betterment, just to take an example—as to how widely that degree of betterment applies to any comparable profession. But the Treasury may have other information.—*Sir Thomas Padmore*: I think we would straight away concede the point. It is very difficult to think of any other comparable occupation, so far as other occupations are comparable, in which there has been no change. The only other occupation I can think of in which there has been no change is the

occupation of a Minister of the Crown, but that is rather a special case, of course.

3514. *Professor Jewkes*: I was really thinking of the earlier points about how much information exists.—I think there is a great deal. It is not comprehensive, as Mr. Winniffrith said, but first of all you have got a good many people in public services who might be thought to be comparable, either because they are members of professions or because their occupations generally were not dissimilar in many respects from those of the professions we are concerned with. There is no difficulty about ascertaining their remuneration. There are members of learned professions in the public services, and in addition there is a good deal of information which either is available or could be fairly readily secured about rates of remuneration in private enterprise for people who might be thought comparable. We have from time to time collected a great deal of information in the Treasury about remuneration over a wide field, including private enterprise as well as the public services, for our own purposes in applying the doctrine of fair comparisons which was laid down by the Royal Commission on the Civil Service. Although it is difficult to get comprehensive information, it is not terribly difficult to get information which we would judge adequate as a basis for general conclusions.

3515. What I was thinking about particularly, of course, were the professional earnings, comparisons between which, and the dentists and doctors, are particularly relevant to our study. So far as I know of them, there are public official figures of the total of professional earnings; there are no public or published figures about professional earnings per head—or at least they have not been provided to the Royal Commission—so the task of trying to compare professional earnings of doctors with other professional earnings up to the moment has proved almost completely impossible.—You had in mind professions such as the law and architecture?

3516. Yes. I think this point will come up this afternoon, Mr. Chairman, on statistics; but I will be satisfied at the moment to say that if you are going to apply the principles of comparing with other professions you have to put yourself in the position of collecting statistics

as to what the earnings of those other professions are.—Anything I said just now was related to salaried professions, of course.

Professor Jewkes: Yes, of course. I understood that.

3517. *Chairman:* Still on this question of the confidence of the profession, and what reasons there are that may be able to be disposed of later as a result of our Report—there is apparently this lack of confidence between the profession and its employers upon whom the profession is dependent not for salaries necessarily but for the remuneration they receive. That is why I asked this question of whether there was any other profession or occupation in this sort of salary range that had not received an increase during that period, and the answer really is that there is not—or certainly not many—that it is pretty well unique.—*Sir John Hawton:* The answer I think is qualified by the fact that one also has to take into account the size of the last change in 1951, not merely the fact that it was in 1951 but the effect it had in relation to pre-war.

3518. As I understand it, Sir John, it could be possible that those who had been practising privately before the Health Service began could already have made a considerable adjustment to the 1939 value of money in 1946, comparing the fees they charged with their remuneration in the Service.—I imagine their fees would have gone up. I am not in a position to give information, I am afraid.

3519. But if they had come into the Service in 1948 without any adjustment in the change in the value of money, they would probably have been coming into a different kind of service and at an income considerably below what they had been earning in, say, 1946 by private sources?—That was the whole point of having an inquiry by the Spens Committees at the beginning, to see first what they should have been earning in 1939—not what they were earning, but a higher figure—and then, how much we should better that by; to give them a square deal in doing precisely what you say, coming into a public service.

3520. And the Government accepted the Danckwerts Award as being a proper one because it was an external decision—you did in fact accept it.—To put it accurately, the Government accepted

the award because it was implicit in the reference to the Danckwerts adjudication that the award would be accepted. I will make no comment on their behalf about the propriety or adequacy of the award. They accepted it.

3521. They did accept it. Therefore in a sense they accepted it as an award that put things right at that date?—They accepted it as the award given in respect of that date. You said, “put things right at that date”. They accepted it as the award given in respect of that date, because they more or less said they would accept it.—*Sir Thomas Padmore:* If I may put it this way, one does not question what the umpire says, even if one may think he is wrong.

3522. *Mr. Gunlake:* I understand that it was said a little while ago that the proper thing was to look back again to 1939, not to build on what happened at the time of the Danckwerts Award.—*Sir John Hawton:* Perhaps I expressed myself badly. When you say, in respect of any body of people, that there has not been any change in income since a given post-war year, that is not the only thing. It might be, to take an extreme case—and I am not applying it to this one—it might be that the last change was of such a kind that it should last much longer than a normal change. As I say, I am not applying it to this one, nor am I expressing any opinion on Danckwerts; I am saying there are two facts. It is not merely that you should have a change over so many years—you also must look at what benefit was derived at the last change, to see if it should last longer than it has.

3523. *Mr. Bonham-Carter:* But the effect of an intermediate award would be of no importance if one repeated the exercise of looking back against the comparison of 1939, would it?—I am sorry; this 1939 is a little misleading. What I am trying to point out is that the whole situation with which we are dealing turns on the different circumstances of the cost of living, the position of comparable employment since right before the war right up to now. One way of looking at it is to say, “You must have, every few years, a review.” I would say that there is a *prima facie* case for this view, with a qualification that if the time you have it is a particularly bad one then everyone considers it a case for early readjustment.

3524. A case for action, but not a case for investigation?—Hence this investigation.

3525. A good many years after surely. We are looking really at the fact that between 1951 and 1957 nothing has been done.—There has in fact been a 5 per cent increase and a 10 per cent increase in some cases given already, pending the result of this inquiry.

3526. *Chairman*: That was in 1957, but from 1951 to 1957 there was no change.—Not for the general medical practitioner.

3527. Yes, we are talking for the moment just of the general medical practitioner's case.—That is quite true.

3528. And that is something which was not really paralleled, as far as we can judge, in any other major occupation.—The fact that there is no change may be paralleled in no other.

3529. *Sir John*, as a general principle, would you regard it as the Ministry's responsibility to inaugurate discussions for increased remuneration, or do you think you should always wait until the other side shows signs of dissatisfaction before starting something off?—In the normal case we should expect it to be done under the Whitley system, and the normal process—here I shall be corrected if I am wrong—is that the receiving side, or staff side, when they decide that there is a case, put in a claim which is thrashed out by negotiation. Is that right, *Mr. Allen*?—*Mr. Allen*: Yes.

3530. But you would expect to wait for an approach before really considering whether the time was due?—*Sir John Hawton*: I should have thought there was no risk of not getting an approach.

3531. That is your experience?—*Sir Thomas Padmore*: It is also the Treasury's experience.

3532. In all matters with which the Treasury deal?—In all matters with which the Treasury deal.

3533. Because this is again this question of confidence. We have a situation which I think is not paralleled in any other major profession, that the general practitioners are not direct employees. Perhaps there is a parallel in the Universities, but there are not many parallels to this system of payment. Would it not have helped to restore confidence

if the profession felt sure that they would not have to be thinking about it for themselves always, but could rely on the Government, or the employer, taking the initiative where changes seem justified—or is that asking too much of the other part of human nature?—*Sir John Hawton*: I should have thought it would be so normal that the professions' representatives would, if they thought there was any unfairness occurring, draw attention to it; so the point would not arise.

3534. You have a special responsibility really, as almost a monopoly employer in this profession?—A special responsibility for trying to be fair, yes.

3535. Yes. It might involve taking the initiative as well as waiting to be asked.—It could do. I do not think it will ever arise, because it will not be necessary.

3536. *Professor Jewkes*: I would like to ask a further question before we get too far away from the Danckwerts award. In the case of that award the adjudicator, as we have been led to understand, looked at two important criteria. He had before him figures of changes in the cost of living and price levels and he had before him figures provided by the Inland Revenue, which remain confidential, of changes in the earnings of other professions; so in fact in that case the adjudicator was applying the two principles which you are asking to be applied in thinking of medical earnings.—Yes.

3537. Do I gather from that that you think the procedure adopted in the case of the Danckwerts award was ideal?—It was rather an unusual procedure, referring to an individual adjudicator in a form which was not an arbitration. But I agree that those are the two factors to which he had regard, and I think he was right to take them into account. That is not to comment on the result but on the method.

3538. *Chairman*: Coming to a more general matter for the moment—perhaps this is for *Sir Thomas*—is it agreed by the Government that the medical profession will not be used as the regulator of salaries and earnings, a regulator if you like of inflation in the community? That is to say, claims should be considered on their merits and regardless of repercussions?—*Sir Thomas Pad-*

more: I do not think there has ever been any suggestion on the Government side that either the professions should be in some way specially sacrificed or that the merits of their claims should not be examined in exactly the same way as those of any other employee of the Government or of any other public service.

3539. That would seem again to be an important thing to establish in the minds of the profession, that they are not being used to hold down salaries. Do you think there are more steps that could be taken to get that frame of mind established?—I would have thought the very establishment of this Royal Commission was a demonstration of it. After all, the Government have asked the Royal Commission to consider on the merits what should be the rates of remuneration, having regard to rates of remuneration in other comparable occupations, which can hardly mean anything but that the Government wishes to treat these professions fairly.

3540. In answer to our question No. 3, in paragraph 15, you tell us the words in which the medical profession were informed of the decision not to consider on its merits the claim for increased remuneration. You said: "The Ministers have asked us to say that in present circumstances they would not feel justified in giving consideration to any claim for a general increase in medical remuneration". . . . no opinion one way or the other had been expressed on the merits of the claim but economic circumstances made it impossible to consider it at that time." That seems to take it rather out of the category of what had been happening in other professions outside the Government's direct control.—Certainly. I think it needs to be realised that this was a short-term question. At that particular time the Government, for what it regarded as overriding economic reasons, was asking for restraint in seeking changes in remuneration throughout the public services, or the services which it financed, at any rate at the sort of levels which are comparable with those in the medical profession. And although as I have said in answer to your previous question, there is no question whatever of the Government wishing to make these two professions regulators in any sort of sense, all experience goes to show that from time to time, for limited periods, it may well

be necessary for the Government to impose on or require from the whole of the public services certain restraints in relation to remuneration. That does not involve any difference between this profession or between the National Health Service and any other public service.

3541. Could you tell me, Sir Thomas, which were the dates during which that particular short-term restriction would have applied?—Roughly from the early summer of 1956, when the Government had under consideration changes in remuneration in a number of other spheres—the judiciary, Ministers of the Crown themselves, Members of Parliament, and the Universities. At that time for, as I say, overriding reasons of general economic policy, what was virtually a standstill was required by the Government, and none of the adjustments contemplated were in fact made, although they had been expected to be made in the summer of 1956. A number of those adjustments came to be made later at about the same time as the interim settlement was made with the medical profession in the early part, and in some cases in the later part of 1957.

3542. Does this mean that if the medical profession had drawn your attention say, in 1955, to the fact that they had not had an increase for three or four years that their claim would have been considered on its merits?—It is difficult to say what would have happened if the timing had been different. If it had not been that the matter was raised at that time when the general policy was what I have described, I think it would have been considered on its merits. I do not know what the upshot would have been, but certainly there would not have been that particular bar to a settlement, a bar which operated for a period of nine months, I suppose.

3543. *Mr. Gunlake*: This is a rather serious point. As I understand it, what you say is that in imposing what you call a standstill, which incidentally is not universally applied, according to the information in your answer to question 18, the Government made no distinction between those sections of the community whose incomes had had adjustment perhaps a little previously, and those which had not had an adjustment for a very long period. Do you not think if it became generally known that this is to be Government procedure in times of stringency, there is likely to be the

obvious inference drawn by the medical profession and others? Who is going to wait five years if that is going to be the Government's attitude?—I am not sure what you think are going to be the consequences.

3544. I should have thought people would take rather good care to put in their pay claims quickly.—I should imagine in these professions, as in other occupations, those who represent the profession make claims for adjustment of remuneration as and when they think such claims are justified.

3545. *Mr. Bonham-Carter*: I wonder if I might pursue this point about representation of the professions. Since Sir John was speaking on this subject I have been trying to think to what extent professions, or people of somewhat similar status in life—not necessarily professions—are in fact represented. Are we not up against something of a problem here, because people in this walk of life normally do not have negotiating machinery. May we not be arriving at something which is in itself a very major difficulty in this whole matter, that the medical profession came into this sort of situation perhaps almost for the first time?—I think it is true that negotiations in the ordinary sense are a relatively rare thing at this sort of level of remuneration which we are considering. Nevertheless, I think in most of these cases, even if you like to take the extreme case of junior Ministers, or the judiciary, whose remuneration has been considered from time to time, an opinion builds itself up, even though there may not be any negotiating machinery, that rates of remuneration are unreasonably low and ought to be changed. In the ordinary way I would have thought, whatever the precise machinery may be—and in the case of the medical and dental professions there is a good deal more machinery than in some of the other occupations—that finally it becomes effective in fact.—*Sir John Hawton*: I think I would not be far from the truth in expressing the view that the British Medical Association is one of the most effectively organised negotiating bodies that any profession could ever have.

3546. *Professor Jewkes*: If I might go back to the answer which Sir Thomas gave—I hope you will not feel these are my ideas I am putting to you, they are

ideas that have been put to us and may in future be put to us. The position in 1956, as you have explained, was that the Government was extremely anxious to stabilise prices and earnings, and as a part of that policy they refused to entertain the idea of any increase in medical earnings. As any schoolboy knows, they were not wholly successful in their anti-inflation policy; salaries rose £300 millions as against 1955, wages went up by £650 millions, prices went up by five per cent. Is it not understandable that the doctors should say: "Why should we bear the main brunt of the anti-inflation policy, because our earnings have been clamped down?"—particularly if the anti-inflation policy does not succeed and the doctors find their earnings meaning less in the way of purchasing power all the time? That, I think, is the question in the minds of the medical profession, and it is one we are very anxious to be able to resolve in some way.—*Sir Thomas Padmore*: I think I can answer the second part of your question first. It is the case that the policy of stabilisation was not wholly successful; and the result of that was that in the early months of 1957, and successively as 1957 went by, the Government recognised that they could not call on the public services any longer to make these special sacrifices in the general public interest, when remuneration in the other occupations was moving up. That is the reason why this thing was of a purely temporary nature, and why the freeze unfroze itself fairly rapidly. Going back to the first part of the question, very naturally doctors and dentists say: "Why should we be sacrificed in this way, why should we be asked to make these special efforts to assist general public policy when other people are not?" The only answer I can give to that is that it is, as I may well say as a civil servant myself, one of the disadvantages of being a member of a public service.

3547. *Chairman*: Sir Thomas, there are two things involved. There is the question of not implementing immediately a justified change in remuneration for reasons of public policy, and that, I gather, is what was happening with, for instance, the judiciary and members of the Crown service—consideration had been given but had not

come to a head. Of the medical profession this was not said, but instead that the Minister did not feel justified in giving consideration to any claim on its merits; they were not prepared at that time to decide what, if there were no inflation, were the merits of the remuneration claim. That is the point.—I think that is a matter which arose merely from the timing of these events. It does so happen that the case of many of the other occupations to which I referred had been under consideration for some time, and what were virtually decisions had been taken—certainly the merits had been studied.

3548. Does not that rather strengthen the argument? It takes time to study the merits, then all the more reason to consider something on its merits if you are not likely to have to implement it until after the immediate future?—Yes, and if I may say so, that was the prime reason for the interim arrangements made in 1957. What I meant when I said that this arose out of the timing, was that it surely would have been a wholly unpractical course for the Government, when they received the medical claim, being in the position that they were in, just unable to do anything, to say: "We will discuss the merits of your claim but warn you in advance that when we have done it you will not get anything out of it."

3549. What I gather they could have done would have been to say: "You will not get anything immediately. This may have to be deferred until other payments have been made from the public purse as a means to preserve this plateau that Suez upset." But consideration seems to me to be rather another matter.—That might have been another course to have taken. In fact, if I remember rightly, consideration of the matter was not deferred for a very long time. I think the claim came in the summer of 1956, and the Royal Commission itself, or the beginnings of setting-up the Royal Commission were in hand very early in 1957.

3550. I was looking for the dates. The Minister of Health was informed on 4th February, 1956, that the profession was going to seek an adjustment, and a precise claim was submitted to the Ministry on 14th June in that year.—I think, if I may say so, being wise

after the event, it is fair to say that a number of months were lost. What the Government decided to do, feeling themselves that they were in a difficult position to consider the merits of the matter, was first to decide that they wanted an impartial and fundamental review by a body like this Royal Commission, and secondly to make, I think, in agreement with the Commission, an interim settlement, an interim improvement in remuneration for the time being for some classes. It might be, as I say, being wise after the event, that a certain amount of time would have been saved if the decision to establish the Royal Commission had been taken in the late summer of 1956, instead of early in 1957. However, I do not think any more than that is at issue.

Chairman: What I think is at issue is the whole question of confidence in the relationship between the Government and the profession, and the absolute need to establish such a relationship if we are to avoid difficulty in the future.

3551. *Sir Hugh Watson:* Both you and Sir John pointed out that Spens directed that regard should be had to two things, first, the cost of living, and secondly the level of remuneration in other professions. Then, when the medical profession came forward in 1956 and said: "What about it?" you say they were told that economic considerations put that out of the question?—Coming back for one moment to the Chairman's point, which is important, about confidence between the Government and these two professions; surely the Government is not wrong in thinking that the best way of establishing confidence on a long-term basis, there having been the history of disagreement and dispute that there has been for so long, for the last ten years between the professions and the Government, is that they should say: "We will ask a body of fair-minded men, independent, with no axes to grind, to study the matter and tell us what they think should be done." And that is why we are here this morning.

3552. *Chairman:* We realise that. We do not know whether the B.M.A. and everybody else accept us in quite that capacity. But it still would be of the greatest importance, long after we have finished our work, that there should be a relation of complete confidence

between the Government and the profession. That is absolutely vital. The reason for going into this is to try to find if we can point a way, even to Government Departments, and even perhaps on such relationships, as to how they can avoid suspicions arising in the minds of members of the profession that can spread a certain amount of discontent. I think you would agree there is a fair degree of discontent about the relations between the Government and the profession?—*Sir John Hawton*: Yes, indeed; and I would like to say I am sure if the result of your inquiry can produce such an understanding no one would be more pleased than we should be.

Chairman: I have not obtained any other impression than that throughout, Sir John. I think we should break now until after lunch.

(The proceedings were adjourned for lunch)

On Resumption

3553. *Chairman*: You know we want to deal with statistical specialist matters during the afternoon, but I think we will come to those gradually and deal with some of the more ordinary matters which the more ordinary mortals ought to be able to understand in the arithmetic, before we get to the other ones that are highly technical. We do not seem to have mentioned very much the Consultants Spens Report this morning, Sir John, and I would like to have a word or two about that. That, of course, was primarily setting up a scale of salaries for hospital consultants, with other posts mainly as training posts. That also has the same famous phrase about leaving to others as to how to interpret the change in the value of money, social status, and so forth? They received a very different addition in respect of these two elements to the general medical practitioner, did they not? They did not get 100 per cent?—*Sir John Hawton*: They got the 20 per cent which the general practitioners originally got; they did not have Danckwerts afterwards, they had a negotiation on Whitley. Unlike the general practitioners, they have a Whitley machine, and on that they did get the settlement of 1954.

3554. We have heard from the profession and we have seen the letter that

was sent by Sir Russell Brain at that time which expressed the view that this established in their view, on the whole, a reasonable balance between the two sides of the profession.—I think the phrase was that it did restore the balance upset by Danckwerts.

3555. It restored the balance upset by Danckwerts—but it was a very much more modest increase than Danckwerts.—Yes.

3556. Further on in your memorandum, in paragraph 93, you show from a series of calculations that the average consultant receives net rather more than 50 per cent more money than the average general practitioner within the age group from 40 to 64?—Yes.

3557. If there had been a similar award to that by Danckwerts, then I suppose they would have received more?—They would certainly have been receiving a great deal more.

3558. Quite apart from the fact that, as far as I know, there has been no betterment applied to merit awards, betterment is only applied to the basic figure?—Betterment has been applied to the actual salary scale, regarding the merit award as an additional fixed bonus put on to it.

3559. That additional fixed bonus has been left throughout in 1939 terms?—Yes.

3560. Was it ever considered that that should be amended at all?—No; you can adopt two methods. You can either pool the merit award with the basic salary and put your betterment on the aggregate, or you can deal entirely with the ordinary basic structure and do all your necessary adjusting in the future as well as the past, and leave the merit award as a fixed additional item. You can produce the same result.

3561. If the balance was restored in 1954 by the adoption of widely differing scales of betterment, it would seem that the relationship was not quite restored by the original basic figure of Spens?—What we are dealing with is the statement by Sir Russell Brain that this restored the balance upset by Danckwerts. If you are asking do we think the relativity is right. . . . Was that your question?

3562. I was taking it that you then thought it was about right, or you would

have offered more?—We reached an agreement under the ordinary negotiating machinery.

3563. You did not beat them down to that figure?—We had no evidence that that balance was very substantially wrong. Really it is anybody's guess, this. I do want to make it clear that you cannot do this on an arithmetical formula; one is salary whole-time or part-time, the other is capitation, with additional fees for maternity and so on. It is very difficult to get a proper balance. But you can get an approximate balance. I would not say that we think the balance is exactly right, but I would say that on what evidence we have got we would not be justified in saying that the differentiation is all wrong. One of the best evidences of that, I think, is roughly the choice of entry into general practice or hospital practice, which shows, I think, that there is not any very swinging preference for one or the other.

3564. I would not be criticising Spens if he had been wrong—he was dealing with the unknown. But in fact, if after 1954 it was right, or about right, then presumably on the straight unbetterment figure of Spens it was wrong.—That seems a reasonable assumption, yes. We think we have got it reasonably right now. I have got here some figures which do bear on this—the percentage increase between 1951 and 1957 in general medical practitioners is 13 per cent; in consultants, including senior hospital medical officers it is 16 per cent. It does not look as though there is an enormous swing one way or the other there over all those years.

3565. From 1951—after the Danckwerts betterment had been added for general medical practitioners?—Yes. It is only on that kind of evidence we can go. I am not pretending at the moment that any of us can say that this is right or wrong—you will have much more evidence on that than I. But on that evidence we should not say it was wrong.

3566. Do you feel, Sir John, from your experience or from Dame Enid's experience, that it is very important to have approximately a right structure and a right relativity within the profession as well as between the profession as a whole and other professions?—It is very important indeed; I should have thought

it was almost more important within the profession.

3567. Yes, I think we have received a growing impression to that extent as time has gone on, and that is why we want to devote some time to these sort of questions. May I turn for a moment from that to the question of dentists, because there are figures there we have never quite understood. I am jumping on a bit, but it arises out of this; if you would turn to your Appendix V, you know that there is a comparison between the statement in the Spens general practitioners report that the average remuneration adjusted but not betterment, would be £1,111, I think, for general medical practitioners. There is a statement that dentists would be earning rather less than the general medical practitioner, based on a certain number of hours, and in times of some difficulty—and that would seem to relate I think a figure of £1,600 for dentists to one of £1,800 for doctors, giving a difference of £200.—Yes.

3568. In paragraph 2 of your Appendix V, you seem again to arrive at the figure of £200 or thereabouts, but it seems to be an entirely different £200; and I personally have not been able to reconcile the figures at all.—Dame Enid is the expert on dentists.

3569. You are there comparing a figure of £1,600, with an increase of 20 per cent., with a figure of £1,100 increased by 85 per cent.?—*Dame Enid Russell-Smith*: Yes, we are comparing the actual figure of £1,920 with a figure of £2,055 for all general medical practitioners.

3570. Yes, you are.—Was the point you had in mind how that related to the Spens recommendation of eight-ninths?

3571. Yes; has that got the slightest relevance to the first sentence in paragraph 1 of the Appendix for instance?

—It has, I think, this relevance, that the Spens Committee contemplated that a fully occupied, fully efficient dentist would earn £1,600 where a general medical practitioner, working in an equivalent sort of way, would earn £1,800. We had taken that sort of relationship as the right one to aim at.

3572. A fully qualified general medical practitioner earning £1,800 in 1939 values would now be earning how much?—In 1939 values . . . ?

3573. In 1957 values, before the 5 per cent.—I am not concerned about the

interim award.—We had taken the actual average of the general medical practitioners and we had taken roughly £200 less than that for dentists.

3574. But Spens did not do that?—No, he did not.

3575. There is no comparison between the two sets of figures?—There is no direct comparison between the £200 in paragraph 1 and the £200 in paragraph 2—no direct comparison.

3576. If there be a relationship to the £1,800 in paragraph 1, it would be with £3,600, would it not now—100 per cent. betterment—not with £2,055?—If one were multiplying up, yes; but the relationship we had taken was this, that where the general practitioner was earning an average as given here of £2,200, the dentist should earn slightly less.

3577. *Professor Jewkes*: Normally about £200 less?—Yes, in that range.

3578. *Chairman*: That is not what Spens said, is it?—No, it is not, but Spens gave a number of criteria for assessing how general dental practitioners should be paid. We tried to construct a system of remuneration based on those criteria and it broke down because the conditions of work at the outset of the National Health Service were presumably totally different from those contemplated by the Spens Committee when they made their recommendations. At any rate, when the Spens criteria were applied to those conditions they produced incomes which were not at all what had been contemplated by the Spens recommendations.

3579. That is to say, they did not produce incomes for a single-handed dental practitioner slightly less than for a single-handed general medical practitioner.—The dental incomes produced by the system of remuneration which we constructed at the outset of the National Health Service were very much higher than I think one can safely say were ever contemplated by either party to the negotiations, and were very much higher than what in fact were being paid to general medical practitioners, and that was the reason why they were altered.

3580. I am still on the question of confidence of the profession not knowing just what the Ministry is going to do and how it interprets Spens. As far as I can judge, Spens in that particular instance

recommended for dentists, in the present time of shortage of dentists—which happens to have lasted some time—something a bit lower than a particular kind of general medical practitioner, but something a great deal higher than the average medical practitioner?—Yes, he did; but Spens again selected a particular type of dentist. He did not make a recommendation relating to the average dentist; he qualified that dentist, and what we have attempted to do is to link dental remuneration generally to the average remuneration of general medical practitioners. It seemed to us the only link that was left to us.

3581. But you say he selected a particular kind of dental practitioner, a single-handed dental practitioner?—A single-handed dental practitioner working efficiently with, I think he goes on to say, all necessary auxiliary assistance, or words to that effect.

3582. That is the one you have selected as being £1,920 net in paragraph 2 of Appendix V?—Yes, that figure relates to those types of general dental practitioners.

3583. Spens never compares that figure at any stage, as far as I can see, with the ordinary medical practitioner?—No, he did not; and as you see that figure is much nearer the average of the general medical practitioner than was the Spens £1,600 and £1,800.

3584. Because the £1,800 compared with an average figure of £1,100?—Yes.

3585. This was a very big departure from Spens.—Undoubtedly, because Spens was found not to work out in practice in the way anticipated in the conditions prevailing at the outset of the National Health Service.

3586. But had you intended to have something that conformed with Spens, if it could have been worked out?—Yes, we had anticipated that the average fully efficient dentist would be actually earning about £1,900 net—perhaps slightly more in view of the overtime that was being worked at the outset of the scheme. What in fact happened was that incomes out of all proportion greater than that figure were being earned. We were able to analyse them later into different groups, and show the spread of incomes in the dental profession, and they were very much greater

than was contemplated when the negotiations took place, and very much greater than could be justified.

3587. I am sorry to keep on pressing on this. This figure of £1,920 that you had aimed at for the general dental practitioner working efficiently—which I think represents a very large proportion of the dentists on the Dentists Register . . . —One has got to take account of age groups there, and a rather unusually large number of dentists were at that time in the higher age groups.

3588. You are dealing with the same figure that Spens mentioned, of £1,600 a year; you say that this £1,600 a year became £1,920?—Yes.

3589. And that figure of £1,920, if they had been general medical practitioners, would have been a figure of £3,200, not £1,920, because of 100 per cent betterment—perhaps 85 per cent betterment?—Yes, it would be 85 per cent betterment.

3590. Which would have been about £3,000?—Yes, at the time we added 20 per cent betterment to both.

3591. *Professor Jewkes*: I wonder whether I could put much the same question in another form. In the Ministry of Health factual memorandum, paragraph 168, you refer to an answer given by the Minister of Health on 12th July, 1955, and there are three figures quoted; there is £2,000 net for the average earnings of dentists, there is £2,200 for the average net income of general practitioners, and there is £2,400 for the single-handed dentist of the age of 35 to 54 working under the conditions you have mentioned. Is this sort of difference, £2,000, £2,200 and £2,400 in fact the kind of principle that you have been applying in the Ministry of Health in recent years in fixing dentists' earnings?—That is the sort of differentiation we have been aiming at, yes.

3592. *Chairman*: To come back once more to the general medical practitioner Spens Report, there is no mention of the central pool in that at all, is there? Do you consider that a fair conception of a central pool was in any way a necessary part of Spens?—It was historical. A great deal of the machinery for general practitioners, both in relation to the distribution of remuneration as well as in many other things, was taken over

from the arrangements under the old National Health Insurance Scheme. There was a central pool under the National Health Insurance Scheme; it was a method of remuneration which commended itself to the profession and in general we made as few alterations in the old arrangements as we could, because we did not want to disturb the confidence of the profession in the methods to which they were accustomed. We believed that to be in accordance with their wishes, and we know in fact it was in accordance with their wishes.

3593. Before the scheme started in 1948, most of the doctors received payment for items of service, outside the old National Health Insurance Scheme?—Yes.

3594. To that extent this was a considerable disturbance of the old methods, in transferring it to a very largely capitation basis.—I would put it this way, that it was an extension to a new class of patients of arrangements with which they were thoroughly familiar in relation to their old insurance practices. I have always myself been quite confident that the profession so regarded it, and that that is how they would have wished it done.

3595. Would that make it easier or more difficult to secure the kind of distribution mentioned by Spens in the Report?—I do not think it affected that question, because the point which made it impossible to control distribution in the way apparently contemplated by the Spens Report, was the adoption of the capitation fee method of payment, not I think the adoption of the central pool. The point about the adoption of the central pool is that it enables the employer to know the sum total of his liabilities.

3596. The central pool is really for the Government's advantage in that sense?—I think it is to the advantage of both parties.

3597. You say it is for the employer to know his liabilities.—It does have that effect, among others, but it has other advantages which have been appreciated by the employees.

3598. The employer has no means of knowing his liabilities so closely in advance in the other two sections of the Service?—No, he has not.

3599. Is that a disadvantage?—I think it is always a disadvantage in dealing with such large sums for the employer not to know his liabilities in advance.

3600. Is he able to estimate fairly accurately nowadays in the hospital service?—In the hospital service, where it is a question of establishment which can be known and to some extent be controlled in different ways, he can, of course, estimate reasonably accurately the amount that will be needed for salaries in that service; but in services which are remunerated on an item of service basis without any kind of central pool, he has no means of knowing in advance the extent of his liabilities, except by previous experience; and certain of the services are, of course, subject to unforeseen variations, which cannot be estimated for at all, with the consequent embarrassment that one has to have a supplementary estimate or something of that sort.

3601. That would be one of the reasons for uncertainty among the dentists, that in order to try and equate the estimates with what is going to happen, charges had to be imposed, thereby reducing the number of calls on the dentists; is that right?—I would put it this way, that no Government can accept an indefinite liability to an unlimited amount, and that if there is no self-regulating mechanism in the system of payment they may be driven to seek other means of limiting liability by limiting, say, demand—as has in fact happened.

3602. Does that mean you would really like to see a central pool system for the whole of the services, so that the employer knows his liabilities in advance?—I do not think it is practicable when payment is made for items of service, but I think it is common ground to everybody that we would like to be in a position to know our liabilities more nearly in advance.

3603. *Mr. Gunlake*: Why is a supplementary estimate embarrassing?—*Sir Thomas Padmore*: The Chancellor of the Exchequer and his staff, like everybody else, like to know as well as they can where they stand, as well in advance as possible.

3604. Is the convenience of all these persons paramount?—I do not think

anybody suggested it was paramount, but it is a fact.

3605. *Chairman*: In the light of experience, I suppose after the Service had started you were able to judge much more accurately than you could at the time Spens was writing his reports?—I think it is fair to say the uncertainty of the Government's liabilities in these respects at the present time is not a fact which gives any sleepless nights in the Treasury.

3606. In fact in that field, the part that has given most anxiety has been that of the dentists, because that has been most liable to considerable fluctuation in total.—*Sir John Hawton*: And at the beginning the opticians; there we were concerned with the same thing.

3607. *Professor Jewkes*: I gather from what you say you think the advantages of a central pool, where it can be employed, for the reasons you have mentioned, are overriding. You probably know there has been some criticism of this central pool put before us, mainly by the Medical Practitioners' Union. Do you attach great importance to those criticisms? It may be you may not want to answer.—I do not mind answering a bit. I think it is really repeating largely what has been already said. The central pool commends itself to us, because we believe it commends itself to the profession, because it has advantage to both, not only the employer but the employee, the one knowing his liabilities, the other knowing his assets, and it is traditional and historical, and everyone is familiar with it. You cannot apply it nearly so equally I think in the case of dentists, because it is made much more easy when the whole profession is sufficiently numerous to take on responsibility for the whole public, and you can have your central pool on a capitation basis; but you have not enough dentists to make that easy. In the case of hospitals, which the Chairman mentioned just now, the situation is entirely different; it is neither a central pool nor capitation, nor is it items of service. In their case it is salary, whole-time or part-time, and you know exactly where you stand. I would say if you want a criticism of the items of service system, which may be inevitable, it is that it is one where you are most uncertain because you are in

fact agreeing to pay for something, the quantity of which is largely out of your control.

3608. The central pool system — as regards general medical practitioners is a continuation, to some extent, of what went on before. Was it based before on the number of doctors or the number of patients?—*Dame Enid Russell-Smith*: It was based before on the total number of patients on doctors' lists.

3609. Now it is based on doctors?—On doctors since the Danckwerts Award. Prior to the Danckwerts Award it was based, as a temporary measure, upon 95 per cent. of the population—the point being that at the beginning it would not have been fair to doctors to base it on the number of patients on doctors' lists, because doctors' lists grew gradually.

3610. The recommendation of Spens does not imply that doctors should average the same amount regardless of whether there are 50,000 general practitioners or 5,000, does it?—No, I do not think Spens took into account the number of doctors nor did he take any precise account of the particular method of remuneration.

3611. Do you think relating it to the number of doctors rather than to the number of patients is a good plan?—Frankly, I have never been able to see why the employer should not pay for the amount of work to be done, and not on the basis of the number of people it takes to do it.—*Sir John Hawton*: I would suggest it is the rather distorted philosophy of people who think that the more money paid into it the better they make sure that they all get something.—*Dame Enid Russell-Smith*: Perhaps it would be fair to say that that recommendation itself in the Danckwerts Award seems to have been intended to be temporary during a period of shortage of doctors. It appears to have been contemplated as a temporary measure and based on a shortage of doctors.

3612. *Professor Jewkes*: The difficulties I was thinking about in connection with the central pool were somewhat different. You know the argument very well yourself. If you have a central pool and if, for example, additional effort is called for from doctors—for polio vaccination for example—then it has been argued by some people who

appeared before us that the payment in connection with that, coming as it does into the central pool, reduces the capitation fee and that therefore the doctors are deprived of any additional payment for what is really additional effort.—I think that needs qualification. In the first place certain, admittedly small, extra payments are made to doctors for vaccination and immunisation. They get, for instance, a fee of 5s. from the local authority for every record of vaccination. That is not a fee for the service, but simply for the record, and it includes an element for propaganda in favour of vaccination, having in mind particularly small-pox vaccinations. Secondly, a good deal of the work which the general practitioners are doing in polio is being done in the form of undertaking sessions for local authorities, for which of course they receive extra payment. They do not receive any extra payment for the actual clinical service that they perform to their own patients. What we would say on that is this, that, as Sir John has previously said, we have always contemplated that from time to time the amount of the capitation fee would need to be looked at in the light of all relevant circumstances. A very relevant circumstance would be a substantial increase in the amount of work done by doctors per patient.

3613. I was quoting the polio case as an illustration. What is the point of doctors, say, asking for an increase in payment for maternity services if, in fact, this has the effect of reducing the capitation fee under the central pool procedure?—The maternity fee does not come out of the central pool, although it does come out of the total remuneration as calculated on the Danckwerts formula.

3614. I would like to see if I have got it right. Supposing the payment for the maternity services were increased, in that case the capitation fee paid would be reduced somewhat, is that true?—Can I explain it this way? Under the Danckwerts formula, which is not inherent in the central pool at all, but is something quite distinct, the amount of a doctor's other professional earnings must be taken into account before calculating the Government's contribution. But prior to the Danckwerts award we had the central pool system, we also had

the maternity payment system, and the maternity payment was in addition to the amount that was put into the central pool.

3615. *Chairman:* That perhaps will lead us to another point which interested us very much. The Spens Report suggested an arrangement for really an average and a spread net remuneration per general practitioner. You have since assumed virtually a uniform percentage of expenses, which is about 33 per cent. on top of that. It has been suggested to us from many quarters that this system is not a very good one, that the doctors' expenses do not go up in anything like a proportion to their size of list, and that this has the effect of greatly increasing the net remuneration of doctors with larger lists as compared with those with smaller lists, because so much of the expenses are basic, regardless of the size of the list. Could we have your views on that?—It is a question of weighing the advantages and disadvantages. We would all like a system which related more nearly the expenses payments made to doctors with the level of expenses actually incurred, subject always to suitable safeguards. But we are dealing with 20,000 doctors scattered all over the country. It is of enormous importance to doctors, and to us, that they should be promptly paid, and that the returns they are required to put in in order to get payment should be kept as simple as possible and should be as few as possible. We would be very willing always to consider the profession's suggestions for trying to make expenses a little bit more realistic in relation to particular groups, but we always have got to weigh against that the very great objection to increasing the elaboration, and above all the delays which come from greater elaboration in the payment of doctors. This scheme is terribly elaborate already; it must be most difficult for individuals to calculate exactly what is due to them and how it has been arrived at as things are, and, while we would be very anxious to explore this, we would always want to have in the back of our minds, and I know the profession would want to have it in their minds, that one must avoid bringing this machine to a standstill by excessive elaboration and refinement.

3616. I do not think anybody is suggesting excessive elaboration and

refinement. Have you read what the Medical Practitioners' Union have to say?—I have.

3617. Did you think that is technically complicated?—You would have to obtain from the doctors their expenses, would you not? You do that presumably on the Inland Revenue figures. A doctor's accounting year ends at odd dates, and you would therefore have somehow to allocate your doctors' expenses into periods. That alone would be difficult. You would then have, when you group them, to do a lot of calculation in the Executive Council paying-out offices to be sure they all got the right addition for the right man, and I think it would inevitably add to the delay in making final payments to doctors.

3618. Would you think a scheme of a basic payment of expenses, £500 or something like that, to a doctor, plus a very much smaller additional capitation sum was more complicated?—I want to make it clear we are always ready to discuss with the medical profession any plan which commends itself to the profession; but in all these things there are refinements, because, for instance, you have got to fix a limit in the size of list below which you will not give the basic payment of £500. Supposing you fix it at 400 patients, you have then got to have an elaborate procedure for making sure you do not give a man who has 399 patients nothing, and the man who has 401 patients £500, and all that sort of thing, and that is what, when you come to work out these plans in practice, immensely adds to the top hamper of the scheme. I am only mentioning these as difficulties which would need to be overcome; they do not necessarily rule out any scheme; but from our experience—and we have had a lot in this sort of matter—one does a little bit blench at the complication which this sort of idea can introduce into a system of remuneration.

3619. You would need something like the present weighting, from 501 to 1,500 patients, an element of that kind?—In a way. It would work that way, yes. That weighting does make the list up to 1,500 relatively much more profitable than the larger lists.

3620. Is there any reason why that principle should not be more widely

adopted if that seems suitable?—There is no reason in logic why you should not alter the loadings in that way if in agreement with the profession you thought it a good thing to do.

3621. It is our job to make suggestions that will produce a fair remuneration in comparison with other professions.—Yes. I merely mentioned agreement with the profession because the sort of working out in practice of this kind of thing affects a doctor's life at very many points. One does want to make sure in trying to rectify one difficulty that one does not create a lot of others.

Chairman: We are conscious of that need too.

3622. *Professor Jewkes:* Do you consider it not worth while to pursue in any great detail the schemes set before us by the Medical Practitioners' Union.—I think you need something much more rough and ready. I would not like to rule out the idea but I do not think you can do it in a very closely defined way.

3623. *Chairman:* I wonder whether anybody else has any points to ask on this particular question; whether we might come on now to these purely statistical ones. *Mr. Nicholson,* I think you are really the person who is prepared to justify the papers on the statistics. Is that right, *Sir Thomas?*—*Sir Thomas Padmore:* Yes.

Chairman: I think *Professor Jewkes* would probably wish to ask most of the questions on these papers, above all the observations which start at paragraph 244.

3624. *Professor Jewkes:* *Mr. Nicholson,* I am quite sure I have not grasped all the subtleties of the paper, as I am not a statistician, but I gather from your paper that there are differences, at first glance they appear to be crucial differences, between the statistical evidence submitted to us by the B.M.A. and some of the conclusions of your paper, so I want to ask you questions under really two heads: the question of the movement of prices, the cost of living for different classes; and secondly the movement of earnings. It does seem to me important that the Commission should understand what the differences are, if there are differences between the

experts, and particularly how confident you are that these differences really would stand examination. The first point is this. In the B.M.A. evidence, reference was made to the index of consumer prices and an increase of 29 per cent between 1951 and 1957. It was upon the basis of that index that the B.M.A. lodged their claim for a 29 per cent increase in earnings. You are suggesting that in fact the probable change in the cost of living of the middle classes in the period 1951 to 1958 was not 29 per cent but was nearer 10 per cent. That is a very big difference and I would just like to explore the manner in which you arrive at it and how certain you can be that it is significant. First of all, I suppose you would agree that your middle class cost of living index number is a residual item obtained by comparing two other series, and if there were any important error in any one of those series then the error in the residual item would be correspondingly greater?—*Mr. Nicholson:* I agree with that certainly. I only do not like its being called my calculation. It is a continuation of a calculation which *Professor Allen* worked out at the time of the Danckwerts Award. I continued it in order to see what result it would produce. I do not quarrel at all with the figure of 29 per cent as being the increase in the prices of all consumer goods—the general consumer price index. We have not expressed any views on which of the two indices is more relevant to doctors.

3625. I see, so that if we were to ask you—leaving *Professor Allen's* calculations on one side and thinking only of the Commission—to what series should we appeal if we were trying to decide how far the cost of living of doctors has changed, what would your answer be?—Firstly, that I think one ought not to switch from one index to another according to which gives the higher result over the period one is considering.

Chairman: It is common practice in negotiations to do that!

3626. *Professor Jewkes:* And indeed, as far as my question is concerned, it is irrelevant because I am not talking about what *Professor Allen* has done but I am simply saying the Royal Commission would like to know to what series it should appeal if it wants to determine how the cost of living of doctors has

changed since 1951?—In view of the fact that one cannot get a very reliable index at the present time appropriate to the middle classes or the professional classes, I think some other index is at the moment preferable. If one could get a more reliable index of the middle class cost of living that perhaps would be more closely applicable to doctors, for that reason I think one might decide to prefer it.

3627. *Chairman*: Have you any even approximate definition in remuneration here of the range of what you refer to as the "middle class"?—No, it is a vague term and different people would naturally interpret it to cover different proportions of the population. I was really using it only in the vague sense of other groups of the population broadly comparable to the doctors.

3628. The doctors and dentists as you will know cover a very wide spread of income—indeed abnormally wide I should say.—Yes.

3629. Were you putting them all in the same box as far as this particular subject went?—I think for this purpose one would take, if one were calculating the middle class price index, people who are not included in the Ministry of Labour's retail price index, which excludes households the head of which has an income of over £1,000 a year. I think you have some information on this, but I should guess that not many doctors come into the group of households covered by that index.

3630. *Professor Jewkes*: So that you think, Mr. Nicholson, that it would be quite proper for us, thinking in terms of the first criterion we have to apply—changes in prices—to think in terms of the movement of an index which shows a 25 per cent increase since 1951?—I think it improper to attach that to a figure arrived at by a different method in 1951 when I think rather more emphasis was placed on the middle class price index. At any rate that was one of the pieces of evidence used at that time. I think one ought to use the same index for the whole period before and after 1951, and I would not be prepared to defend any procedure which involved using one index for one period and another for a later period. I think if you take the whole period since 1939 there is not very much difference between

the two. It just so happens that this rough calculation of an index for the middle class was higher in the earlier period and lower in the later period.

3631. *Professor Jewkes*: Then I would really repeat the question. Leaving Professor Allen on one side, would you feel we would be wise to take since 1939 this index of general consumer prices as our basis of how far the cost of living has risen for doctors? I am simply looking for a basis. Would you be quite happy if we used that particular index all through?

Chairman: You are talking in terms of Spens, not our terms of reference?

Professor Jewkes: No, I am not talking of our terms of reference. I am asking how far the cost of living of doctors has changed since 1939. Would you feel we would be wise if we used the general index of consumer prices as given in the Blue Book?—It is a little difficult to say. I think one perhaps could suggest that you should take account of the fact that the middle class price index shows a lower increase. The calculation is rough, but it is not so rough as to suggest that it could have shown the same increase as the general consumer price index.

3632. I would be quite happy if your Department could provide us with an index showing the changes in the cost of living of the middle classes since 1939. I am simply looking for what you would regard as the most reasonable series to employ for this purpose. Could this be done?—Given time, it could be done. I think it is difficult to account for the big difference between this rough calculation appropriate to the middle classes—I call it middle classes, call it professional classes if you like—and the 29 per cent shown by the general consumer price index. One can easily understand an error of 2, 3, 4 or 5 per cent creeping into a calculation of this kind, but not an error of 18 or 19 per cent.

3633. This is exactly the reason why I am trying to get something secure to which we as a Commission can appeal. We are really confronted with two figures showing an increase of 29 per cent and of 10 per cent. There is a big difference between them. Would you be quite happy if we used the figure

showing the increase of 29 per cent all through?—The 29 per cent is certainly a more accurate estimate of what it purports to measure—changes in the prices of all consumer goods—than the figure of 10 or 11 per cent.

3634. This is what the B.M.A. did: they used the 29 per cent, did they not?—Yes, but I have a suspicion they used it because it came out to their advantage to do so.

3635. There are two figures and we are really asking you as an expert to give us guidance as to which is the more reliable figure. I would like your advice on it.—I think the question, if you had accurate indices of both kinds which would you prefer to use, is one which perhaps it is not for me but for the Royal Commission to decide. If they asked me, I would say an accurate and appropriate figure for the middle classes seems more closely to measure the sort of things that one is trying to measure here.

3636. That index in fact does not exist, does it?—An accurate index of that kind does not exist but it is easy enough to do this rough kind of calculation. That suggests that, if an accurate index were available, it would be substantially lower than the general consumer price index. It is rather difficult to believe it would be above 20 per cent in the light of the results of this rough calculation, perhaps easier to believe it is nearer 10 to 15 per cent.

3637. Are you acquainted with the unofficial middle class cost of living indices? One was quoted to the Commission some time ago in a statement prepared by the "Economist." That was the cost of living index number for the middle classes which in fact showed a very much larger increase than the 10 per cent suggested by your calculations.—I have not seen that.

3638. Could we turn to the second criterion, the question of earnings, where the difference between you and the British Medical Association seems to be this. The B.M.A. quoted figures of professional earnings between 1951 and 1956, showing an increase of 25 per cent. Those of course were total earnings, not per head, but the B.M.A. indicated to us that probably on the whole there has not been much change in the number of earners and therefore 25 per cent was perhaps a reasonable guess for the

period. Then in your document you are suggesting that figure should be 8 per cent not 25 per cent. Could you explain to us—I think the Commission would like to know—how you got that figure which is so different?—A large part of the difference is explained by the fact that when the submission was made by the B.M.A., they had figures available to them which have since been substantially revised. In April, 1957, when the official estimates appeared for 1956 and earlier years, the estimates which led to the figure of 25 per cent were revised and produced a figure of only 13 per cent increase in total income. I think the B.M.A. could not quarrel with the fact that the figure had been changed, and they would now have to switch over to the new evidence on that. The rest of it is just a matter of estimating the number of persons covered by this estimate and that information is supplied to us by the Inland Revenue. An estimate of the number of incomes in this category shows an increase of roughly 5 per cent; dividing that increase in numbers into the increase in total incomes, we get an increase in average professional incomes of about 8 per cent.

3639. You see, Mr. Nicholson, this figure of the number of earners has not been made available to the Royal Commission and what I would like to say is, since the figure now has been used in the denominator, could we have those figures given in the Blue Book divided by the number of earners for each year since 1938?—There may be some difficulty about getting a figure for 1938. It can be done for a run of years.

3640. Could we have it for as long a run as you can make available to us? Because this in fact is the important thing. Up to now we have been confronted only with total earnings and we want earnings per head.—Whatever information is available to the Inland Revenue could of course be made available to you. I think they may have to qualify the figure for 1938 and say it is a rough estimate, rougher than the figures for later years. I think you probably understand the qualifications attaching to these figures already.

Professor Jewkes: Yes indeed.

3641. *Mr. Gunlake:* You mentioned just now the number of incomes included in these figures in the Blue Book. Am I

not right in thinking it is the number of Schedule D assessments?—It is—I think you are right—incomes of self-employed professional people including part-time people as one unit.

3642. What about a man who is assessed under both Schedule D and E?

Chairman: This is limited to professional self-employed people, the part-time consultant, for instance, is included?—He is included in the figures if he works part-time as a self-employed consultant.

3643. Even if he is nine-elevenths employed by a hospital, and two-elevenths in private practice?—Then he is included in these figures.

3644. For the whole of his earnings?—For that part of his earnings he derives from his self-employed work.

3645. So although he appears as a person it is only two-elevenths of his time?—Yes.

3646. That would give a misleading answer, would it not? In fact very much so for doctors because nine-elevenths is a very common degree of employment as a consultant?—If the proportion of part-time self-employed professional persons is substantial, and if that proportion is changing from year to year, it would disturb the comparison.

3647. *Mr. Gunlake:* We know it is changing, of course.

Chairman: And we know it is changing very substantially for doctors.—It has been said that it is changing and that the change is substantial. We have no actual information.

3648. We know the total amount of people who have some self-employment is substantial.—*Sir Thomas Padmore:* One is not looking at this for absolute levels of remuneration. One is looking for the change. To that extent this kind of operation is less depreciated by the inclusion of part-time than it otherwise would be.

3649. *Professor Jewkes:* Unless the proportion of part-timers was changing. *Mr. Nicholson:* The proportion needs to be changing and it also needs to be substantial.

3650. I would not press the point further. You know what we would like here. We would like to get professional earnings per head corresponding to the

figures that are given in the Blue Book for total earnings of professional persons for as long a period back as we can get them—to 1938 if possible. The other point I wanted to raise is this. You probably know certain figures have been given to us by the Inland Revenue for recent years. I may be wrong about this, but at first glance it appeared to me your conclusions were not consistent with the figures given to us by the Inland Revenue. Am I wrong in that?—I think they do not cover quite the same group of people. I think I am right in saying that their figures are limited to specific classes of professional self-employed people, and the figures we have quoted here cover all self-employed professional people except general practitioners.

I think I am also right in saying that their figures do not refer to the same period. Both the starting points and the end point of their figures are substantially earlier than the starting and end points of this calculation.

3651. They give a bigger percentage increase than you give.—Both sets of figures are derived from the same source—from Inland Revenue returns.

3652. I am just wondering what the basis of calculation is, for example, in the figures you quote showing an 8 per cent increase only. Those figures include dentists, do they not?—They include dentists.

3653. They include consultants too. The dentists' earnings in the part of the period you cover were actually going down. That would mean if you could separate out the figures of the earnings of doctors and dentists, perhaps what was left would increase more rapidly than your 8 per cent, and that might be the explanation of this apparent diversity?—I should be very surprised if the exclusion of dentists from these figures made a difference of more than 4 per cent.

3654. Total dental remuneration is about £40 millions, is it not, and the figure has been going down. It is a substantial figure, what is left?—It is—a figure of the order of £200 millions.

3655. You see the point I am getting at, the third point, is a rather more general point. At various places in the document you refer to the Danckwerts Award and unless I am mistaken you are implying that in some way the Danckwerts Award did not establish

appropriate relativities. In paragraph 250 you say the B.M.A. assume that changes in prices and salaries between 1939 and April 1951 were correctly taken into account by the Danckwerts Award and you talk about changes in salaries since 1951. My interpretation of the Danckwerts Award is that it was an attempt to establish appropriate relativities; that the adjudicator in that case had his information about price changes and changes in earnings, and that it was upon that basis he reached his decision. Is that wrong?—*Dame Enid Russell-Smith*: The terms of reference of Danckwerts did require him to take account of both the changes in the cost of living and the incomes of other professions, and he went into both those points.

3656. So if the adjudication was correct the proper relativities were established?—*Sir John* has just explained that while the Danckwerts Award was accepted it was not what the Ministry had argued for before Danckwerts.

3657. *Chairman*: You say none the less "changes in the cost of living". The actual words were "changes in the value of money". You do not take that as necessarily the same thing?—*Sir John Hawton*: The only words we would perhaps reflect upon in the question were—"if the adjudication was correct".

3658. *Mr. Gunlake*: The point we are pursuing here in paragraph 250 is that in that paragraph it is objected that this method of dealing with the thing in three bites is wrong. That can only be so if the Danckwerts Award is considered a wrong award. Is it your position that you are in fact trying to get round it?—We never try and get round a thing we accepted. I say we accept it, full stop.—*Mr. Nicholson*: The point of the remarks in this paragraph 250 is really that the appropriate relationships in other professions had not in 1951 been established, for example, in the Civil Service, and so suitable changes were made in salaries in the Civil Service subsequently to 1951 in order to bring about a more proper level between Civil Service salaries and those of other professions.

3659. *Professor Jewkes*: Surely the adjudicator had available to him the statistics of earnings in other professions and by appeal to those he presumably sought to establish the correct relativities? The point I am trying to get clear can be

well seen in a specimen sentence where you say:

"Changes that have taken place since 1951 in salaries in other professions, e.g. of University lecturers, teachers and Civil Servants, have probably led to more normal relationships generally."

Now that suggests that the Danckwerts Award in 1951 established relationships that were not normal.

Chairman: It was a step ahead.

Professor Jewkes: The suggestion seems to be it was a step ahead?—I think that is the suggestion. At no time can one ever say anything is normal.

3660. Would it be fair to mention we are again up against these two conflicting criteria? The 100 per cent betterment was perhaps nearer to the changes in the value of money than it was to the changes in incomes of other professions?—*Dame Enid Russell-Smith*: That I think accounts for the difference.

3661. Is there any evidence—if so can we have it—that the changes in professional earnings that the adjudicator had to deal with showed that 100 per cent increase for doctors would be abnormal?—The simple point I am making is that I think the 100 per cent betterment was more in line with the changes in the value of money than it was with the changes in earnings in other professions.

3662. *Chairman*: *Professor Jewkes* was wondering whether there was any evidence to that effect. I thought perhaps *Mr. Nicholson* might know the extent to which other professions had in fact increased. I know here we are faced with the position in any case with the general practitioners that the 100 per cent was added to an increased figure for 1939; was not added to 1939 but gave a betterment over 1939 of something like 138 per cent. Have you *Mr. Nicholson*, while we are at this point dealing with the past, actual evidence as to how much people in these different levels in other professions in 1951 had at that time gone up in comparison with pre-war figures?—*Mr. Nicholson*: We have not got comprehensive figures but the information available certainly suggests that the average increase was less than the amount awarded to doctors at that time.

3663. *Professor Jewkes*: Certain figures of professional earnings between 1939 and 1951 were put in the hands of the adjudicator, and upon the basis of that he made a decision to increase general practitioners' earnings by 100 per cent. Have we any reason to believe that the figures he was using for other professional earnings showed a smaller percentage increase?—I think those figures were limited to self-employed professional people in about half a dozen professions only and did not take into account any salaried professional people.

3664. *Chairman*: It is really the self-employed branch we are dealing with as regards the Danckwerts Award, are we not?—People who are comparable.

3665. Salaried professional people compare more with the hospital doctors who are also salaried. For this purpose I think it is right to take the self-employed people in other branches. That is what I take it you mean when you say the evidence to Danckwerts, such as it was, was that the 100 per cent reflected more the change in the value of money rather than the change in the value of the earnings of other comparable professions?—I think the figure available of the increase in average professional earnings was less than 100 per cent at the time of Danckwerts.

3666. Even there I suppose it varied considerably for the people at the bottom end of the list and those at the top end. It was not a uniform increase, was it?—I am sure the increase must have varied quite a lot from one profession to another and also at the different ends of the scale for each profession.

3667. *Chairman*: You have not got any figures on that?

Professor Jewkes: You think it is less than 100 per cent. How much less?—I am not thinking about this. I am just saying I know what the figure is that was put in from the Inland Revenue. I say it was less than . . .

3668. I know the figure too, so let us discuss it. The figure that was given to the adjudicator was a figure based on 1937 as I understand it. Was that correct?—Your memory perhaps is better than mine.

3669. In the discussions that went on at the Danckwerts proceedings a good deal of confusion arose because the Inland

Revenue figure was a figure based on 1937 and the B.M.A. figure was based on 1938. These two figures were not very different and in fact they were both consistent with the increase that the adjudicator awarded of 100 per cent. Is that not correct?—The figures used at that time were not very different from each other. The figures about changing prices, too, were not all that different. You know and I know what the difference was.

3670. If that was so how can it be said Danckwerts Award in any way created abnormal relativities?—Can I perhaps be allowed to explain the main point of what we are trying to say here? It is that if one is asking oneself the question, what ought salaries to be at the present time in relation to what is being paid at the present time in other professions, it is going at it in rather a roundabout way to first of all take 1939 as the starting point, then to consider the increase between 1939 and 1951 including the Danckwerts Award, and then to look at the increases between 1951 and the present time. Some of the figures are not the figures one would like to have. They do not cover all professions. For instance one of the figures used was professional incomes excluding salaried professional people. One does not have an accurate middle-class price index. The main point of the remarks in this paragraph is that one is more likely to get an accurate and generally acceptable result if one goes straight into the problem of what should salaries be in relation to other professions now, rather than doing it in this roundabout method involving inaccuracies at every stage.

3671. *Mr. Gunlake*: You are contending that the right thing to do is to make a comparison with levels of remuneration in other professions. At the moment there is a very considerable lack of information about other professions as to what their earnings in fact are. Had it occurred to you that as soon as we publish our Report and statistical appendices, at least some of those other professions may say: "This is not good enough; we are going to alter our standard of remuneration". Why is it thought this yardstick of other professional remuneration at the moment is something fixed and immutable?—I do not think anybody here would say

it is fixed and immutable.—*Sir Thomas Padmore*: Could I just add to what Mr. Nicholson said? The other great difficulty, apart from the inaccuracies of what he called a roundabout method of looking back to 1939 and 1951 and looking at changes between then and now in order to attempt to arrive at a proper and just deal for these professions, is that any such procedure involves an assumption that the state of affairs which existed in 1939 and that which existed in 1951 was necessarily right. Further, even if it was right then, that that state of affairs ought to continue to exist now.

3672. Would you think the state of affairs existing in 1951 was right?—Not necessarily. Nor of course do I make any assumption about the rightness or wrongness of the rate of remuneration received by other professions. All I say is that it is right and fair and just that members of a public service should be remunerated at the same sort of levels in relation to what they do as are members of other occupations, whether inside or outside the public services.

3673. *Chairman*: That will be a changing relationship over the years?—*Sir John Hawton*: That brings you to (c) of your terms of reference.

3674. *Professor Jewkes*: On this difficult matter we cannot draw truth from the air. It is true that our questionnaire will show us relative earnings in different professions in 1955 and 1956. That will not really tell us whether these relationships are right. We clearly have to go back a little to see how earnings in different professions move, the history of all this. What I am anxious to do is to try and simplify our task. Can we assume in 1951 there was this award, that this is a good basis from which we can start thinking forward? A good deal has been said today that throws doubt on that 1951 award. I am very anxious to know just how serious is the suggestion that the Danckwerts Award created abnormalities which it may be our task to try and deal with.—*Sir Thomas Padmore*: I would not dispute the relationships of 1939 or 1951 or Danckwerts. All I would say is that if you base yourself primarily on an adjustment of the historical situation by reference to what has happened within the profession and what has happened elsewhere, you will not be carrying out the job involved

in your terms of reference. I therefore suggest that ought not to be your primary approach.

3675. *Chairman*: I think we have covered this part sufficiently for the moment.—If I may just add, Professor Jewkes said he was very anxious to establish the extent to which we were, as it were, asserting that 1951 had created a state of affairs which was unduly favourable to the general practitioner. I think that what is said here we would hold to. You will notice that in paragraph 250, it is said that "the assumption that, by 1951, the appropriate relationship had been established between salaries in the medical and other professions is open to question." I know of course the remuneration of general practitioners is not salaried, but I think we go on to speak here about University lecturers, teachers and civil servants. I think we would say that while the direct and natural comparison for the general practitioner is not of course with salaried classes, nevertheless we would have held, if we are looking at the comparison between 1939 and 1951, that the Danckwerts Award did put the general practitioners well in front; well in front, in that same kind of comparison, of other salaried classes—though they themselves are not salaried—in particular in front of such people as we mention, University lecturers, teachers and so on who had certainly not had between 1939 and 1951 anything like 100 per cent. betterment.

Professor Jewkes: I had missed the significance of that point.

3676. *Chairman*: Might we turn to a different point on the relationship of the two sides of the profession. It seemed to us, Sir John, one of the things that has emerged as time has gone by at various meetings, that there is undue difficulty, part of which is due to the levels of remuneration, in the transfer of a doctor who aimed at being a general practitioner and then wants later to go on to the hospital side; or who aimed at being a consultant, is not a failure but has changed his mind and wants to go on to the general practitioner side. There seems to me undue rigidity in the two sides of the Service. We have had that fairly generally handed to us from time to time or it has emerged from discussion, and it has emerged that really the remuneration in the two sides ought not

to be such as to be an undue barrier to fluidity within the Service. What would you think about that in general terms?

—*Sir John Hawton*: There are two points are there not? First of all are you saying only remuneration acts as a separating wall?

3677. No, there are other things as well. What seemed to emerge is that there are many difficulties, but that remuneration itself ought not to be an additional barrier in an already rigid structure.—*Dame Enid Russell-Smith*: It all depends, does it not, on the stage at which a doctor wishes to pass from one branch to the other, dealing solely with the remuneration question, because of course, there are these other barriers as well. If he passes straight from the hospital training machine there is surely no barrier.

3678. There is no barrier at the end of his first year as house officer. Then he can do either. But from then on the conditions tend to alter.—*Sir John Hawton*: Is it not partly a question you asked earlier about the differential in payment between the two sides? That I should have thought was answered by saying we do not think the differential is necessarily wrong. We would not go so far as to say it is ideal and perfect. We do not say it is wrong according to the evidence. What I should have thought was the really important thing—you must remember I am speaking as a layman and you will get your expert evidence from elsewhere—is to see that the result of this is not to separate the whole working life of the general practitioner and the hospital staff too much. And on that it is a matter of doing all kinds of things—an accumulation of things—to bring them together. I mean, the kind of things we have done. I think we have set out some of them for you. The kind of things we have done is to encourage the general practitioner to have charge of wards. The number of general practitioner hospitals has gone up. We encourage the specialist doing a domiciliary visit always to have the general practitioner there, so that they work together. We encourage every kind of facility to the general practitioners to go into the hospital where the other side of the profession can use their resources. These are all encouragements. In the last resort in my lay experience it depends so much on the people themselves.

One has met general practitioners whose whole anxiety is to follow their patients right through specialist treatment, to get in the hospital if they can. One has also, I am afraid, met general practitioners who take the view: "I wash my hands of this: it has gone to hospital." But all of these things can only be done by persuasion.

3679. I was not comparing the remuneration normally earned by a consultant and that normally earned by general practitioners. The consultant is firmly established. It is the stages between a doctor's first year as pre-registration house officer and that of perhaps the senior registrar that I am thinking of. It is round about there it has seemed to us that the people might have decided after all: "I do not want to specialise." They should be able to change more readily and remuneration should be no bar at that stage. In a very important section of your memorandum that starts, at paragraph 47, you lead to the conclusion for the setting-up of the registrars and senior registrars as purely training grades. But that will not work on account of numbers.—This is a very difficult subject. I do not want to take too long, but it is very important.

3680. I hope you will: it is important.—It is very important and difficult and at this moment is under active discussion at Ministerial level with the Joint Consultants Committee so that I must be reserved in the sense that no decisions are reached. On the starting point, as far as I can remember, the Spens Committee worked on an assumption that the consultant is your basic grade but all other grades like the senior registrar and others were really steps in training grades. The steps below the consultants were more or less all training grades leading up to consultants. I think no one doubts that the consultant is the basic grade and no one is questioning that, but the result has been that you have had rather more senior registrars than can be absorbed as consultants. You have had a very awkward problem as to what happens to them, which has been patched up for the time being by keeping them year after year doing a job until a solution is found; you have had to invent a grade not envisaged by Spens, a senior hospital medical officer between the consultant and the senior registrar, in order to do specialist work which was

not quite of consultant status. The whole point I think at issue is this—is there work of a really specialist kind to be done which is not quite suitable to be rank as full consultant status? It leads you to quite a number of possibilities. I want to make sure in view of the present situation I am only mentioning them as possibilities. One which is constantly suggested from some sources is you should have a new grade of assistant consultant, the full consultant taking all the ultimate responsibility, the assistant consultant with a permanent post, unless he is promoted in a temporary training post, doing specialist work of a less vital kind to relieve him. Whether in other words you are going to alter the hierarchy of the hospital by introducing the conception that there is room for somebody to do specialist work—I nearly said of a routine kind but that is not quite fair. The specialist work would be a little below that of the full consultant who cannot be defined but is obviously a person who through his skill and experience is competent to take absolute ultimate responsibility for any case in his specialty.

3681. May I interrupt for one moment? You said, the full consultant who cannot be defined?—I tried to give a rough indication of the definition.

3682. That has been uppermost in many of our minds, the difficulty of defining consultant work and the need to have some kind of a criterion if you are not to have many members of the profession saying we are doing consultant work but not being paid as such.—I am very well aware of this difficulty. You do realise it is impossible to define in any legalistic form the work of a consultant. I am not thinking of a definition but the essentials of it. I think it would be the ultimate responsibility for his specialty in the hospital and that leads to the fact that somewhere below that is the level—which he may be at now—which is specialist but is not quite of that degree of ultimate responsibility. One can only adumbrate the sort of thing. I am not for one moment saying, and I am not advocating—it would be quite improper for a layman to advocate—that there should be that grade, but I think most people recognise that there is special work in hospitals other than in training—specialised work which has got to be done

by someone. There will always be a query whether the senior hospital medical officer is really a consultant being underpaid, that kind of thing. That we are trying already to enquire into fully with the profession in order to see if there is any truth in it, though in fact the position is that over recent years the number of full consultants has increased faster than the number of these senior hospital medical officers who it is alleged should be consultants. Now that is the general situation and at the moment, as I say, the possibilities of altering or reviewing the whole structure which does not seem to be working in the way Spens envisaged is being considered immediately by the Minister, who may indeed be making some kind of pronouncement very soon. So it is difficult for me just at this moment to answer. Much as I would like to I am not able to say much more because I do not know any more. And it is a highly professional question. It would not be right for me to give any direct opinion. But that is the point and that I think links with your other main problem because whatever the merits of these suggestions they must be thought of against the background of the hospital structure, of the kind of person you have got in specialist work in hospitals.

3683. We have a good many problems within this general field—we shall not get them all dealt with today—including the questions of peripheral hospitals and teaching hospitals. Sir John, how is the establishment of consultants settled?—The establishment is controlled to the extent that it has to be approved now by the Ministry, but naturally it is the Regional Hospital Board or the Board of Governors of the teaching hospital which in the first instance decides on the advice of its professional advisers what is needed. There is still this need for getting approval to an upward alteration of numbers from the Ministry, but that is rather a red herring. That point about the Ministry's approval comes for other reasons, not because the Ministry know more about it. They do not pretend to. It is largely because one has to have some check on development and expenditure. But it is the Regional Hospital Board and the Board of Governors with their advisers who decide what is needed and what expansions are needed. The service is expanding all the time. There is some sort of criterion to guide

them as to who is a consultant, what is a consultant, what is consultant's work, and whether or not there is a shortage or a surplus of consultants in any particular specialty in any particular place.

3684. There is provision for reviewing the people graded senior hospital medical officer who think they should be graded as consultant and have not been. The real problem is whether you want to accept completely a potentially permanent grade of assistant consultant working with the consultant.—Just one other thing on this. Scottish practice differs from English and I am sure you will want to hear something about that at your convenience.

3685. We have not heard anything from Mr. Anderson.—*Mr. Anderson:* There has been no occasion. We have brought out later on in this same paper, in paragraph 68, something of an outline of the different Scottish tradition in this matter of staffing structure. In that, we have described our general method in which the teaching hospitals in Scotland, which, of course, comprise a considerably larger proportion of the total than the teaching hospitals in the south, are organised. The question of staffing structure is one that we have discussed over the years with the profession in Scotland and we have from time to time come, we thought, almost within sight of agreement. Indeed at times we have even reached agreement in principle but unfortunately it has never been possible to translate it into a precise scheme. I think the situation which gives rise to this is reverting again to the question of structure, the existence of something in the nature of a hierarchy in the teaching hospitals. The general practice has been to organise, at least so far as main specialties are concerned, in units, each one with its own beds, somewhere around 60, with its share of out-patient work and, through the other appointments of its senior members, a connection with the non-teaching hospitals. A unit of this kind is far beyond the capacity of any one person and the practice has been for it to be staffed on a team basis with two or three or even more doctors of mature skill and experience, together with the training grades and house officer grades. The seniors all exercise clinical responsibility for the treatment of the patients in their charge. They all admit and discharge

patients and they usually see out-patients, but there is a senior known as the chief or the consultant in charge who carries a recognised but rather undefined responsibility for the unit as a whole. One would say in general, I think, that he maintains a general supervision over admission, ensures that the staff coverage is adequate at all times and used to best advantage, and he speaks for the unit in matters of policy and administration. The other senior doctors have been traditionally known as first assistant, second assistant, and so on. This as I say applies particularly in the teaching hospitals and there particularly in the main specialties, although it exists to some extent in the other specialties. There are signs of something of the same kind developing in the non-teaching hospitals, at least in some areas. So while, as I say, we cannot claim that we have found the answer to this difficult question of staffing structure, at least it seems to us that through the Scottish tradition we are perhaps nearer to the answer than has been the case in the south.

3686. All these people in the Scottish hospitals are consultants?—Yes.

3687. With the full permanent consultant status?—That is so, yes.

3688. And all eligible for merit awards. They may be nominated for them?—Yes, certainly.

3689. You know, Sir John, on this question of establishment I was mentioning just before, it has been suggested to us by many people that the simple answer to many problems is just to make a whole lot of people consultants?—*Sir John Hawton:* Yes.

3690. But do you think broadly speaking you have got about the right number of consultants?—I am not saying we have made our minds up but it seems to us there might well be room for someone who is not taking the full responsibility but doing slightly less in specialist work.

3691. I mean, you are not holding down the number of consultants below the proper establishment?—No, the number of consultants is increasing more in proportion.

3692. For instance there is no Treasury veto that prevents your making somebody consultant and making him do

the same work for half the price?—For once, without intimidation, I can say no!

3693. Because you know that has remained the impression in the minds of some doctors.—It is not true.

3694. *Professor Jewkes*: Whatever decisions are made you are clear in your mind, are you, that merit awards should not be applied to any new grade?—No. I was not stressing that for a moment. What is done by merit award must be related to a structure. I am not for one moment making any suggestion as to whether one grade or any other should be entitled to it.

3695. I had rather got the impression that there had perhaps been undue inflation of merit awards due to the increase in the number of consultants over the past ten years or so.—No, I did not say that.

3696. *Chairman*: In fact I think we have not yet got figures about the proportion in each specialty that is liable to get merit awards during their lifetime.—I am sorry you have not got them, but I should like to say here and now there is no fixed proportion allocated to each specialty.

3697. We realise that, but in fact it means, does it not, that with the great increase in consultant establishment since the 1948 Spens Report, that general medicine, general surgery etc., have considerably more than a third of all consultants getting merit awards now?—I would answer that by saying it is inherent in the present merit award system that it is allocated to individuals on their merits, and one could not expect to find merit apportioned on any formula among specialties. One must find out—that I think is the answer to that—whether it is the right system. That is the principle at the moment.—*Sir Thomas Padmore*: If I may say so, I hope that the Commission will not expect anything in the nature of a forecast of the numbers of consultants likely in the future to receive distinction awards. They will not expect anything that would involve looking into a crystal ball. The system provides that at any one time 34 per cent of consultants have merit awards. You might find it working so that everybody would get an award at some stage in his career. On the other hand, if they were all awarded

immediately on completion of training only 34 per cent would get them. What the actual figure is going to be in between those two I do not think anybody will know until the service has been run for a good deal longer than it has now. This is affected by the age spread at any one time within the consultant group.

Chairman: We have received some pretty fair indications in general on that. I think Lord Moran had the figures when he came showing the ages at which in different years C, B and A awards on the average had been given, which was quite a useful indication.

3698. *Professor Jewkes*: I am sorry I had not the exact reference, Sir John, when I asked my last question. It is in paragraph 65. There is a comment to which I would like to draw your attention, in sub-paragraph (c):—

“As the number of consultants increases, it seems open to question whether the proportion meriting distinction awards remains constant at 34 per cent.”

I had rather drawn from that the implication that you felt if the number of consultants increased, or if indeed there was a new grade, the 34 per cent should decline—that perhaps the absolute number of distinction awards should remain constant.—*Sir John Hawton*: We have not said there the number should decline; we have only said it is obviously a point you will want to consider: whether there is magic in the 34 per cent if the total numbers alter, or whether one is to assume that merit automatically rises and falls with the total.

3699. *Chairman*: I think, Sir John, paragraphs 64 and 65 taken together showed that this was one of the points where you were being rather neutral, putting out both sides and leaving us to make up our minds.—I think I did explain just now it is inevitable that we should be a little neutral. You have heard already the profession on it, and there are discussions going on.

3700. *Chairman*: I do not believe there is any more convenient point at which to break off than that, because I think we are rather in the early stages of discussion that may go on for some time on this question of hospital staffing and the relativity between the two branches of the profession. So we might

as well stop now. And we considered that we would start at 10.30 instead of 11.15 so as to have a full session before lunch, if that is agreeable?—*Sir John Hawton*: Thank you very much.

(The proceedings were adjourned until the following day)

Friday, 18th April, 1958

On Resumption

3701. *Chairman*: Sir John, could we go now to the answer to question No. 4 which begins at paragraph 19? This is really entirely dealing with the question of recruits to the profession, and raises rather an important question of principle at the end of it. But on the question of recruitment and training it has been said by some people that the period of training even for doctors and certainly for dentists is too long. By some others that has not been expressed as the view. Might we have the Department's view on that question?—*Sir John Hawton*: I really think this is the first time where I should say that we should not have a view. We scrupulously leave to the professions and their own organisations all questions of their own educational ideas and that kind of thing. We keep right out of telling professions what kind of qualifications they should have and how long the period of qualification should be. I hate answering unhelpfully, but I really think that is the right attitude in any Government Department.

3702. You did know, did you, that that had been suggested?—Yes. I think it is for the professional bodies of all kinds themselves to give you evidence on that and not for a civil servant.

3703. On the question of the McNair Report and the dentists, you point out that the capacity of the schools is virtually taken up now?—Yes.

3704. And that some steps are being taken to increase the capacity to a thousand?—Yes.

3705. Have you any idea whether, if it were a thousand, that many places would now be filled?—That was the rate of output which the McNair Committee recommended.

3706. But do you know the numbers of recruits now coming forward? It

can, I suppose, only be an estimate, but would you think they are coming forward in sufficient quantity?—We have not got the accommodation.

3707. If you had?—If there were, would there be enough recruits? Is that the question?

3708. That is the question.—It is a little hypothetical.

3709. Yes.—I should have thought, on the question of recruits coming in, it looks as though there would be sufficient.—*Dame Enid Russell-Smith*: What we can say with confidence, following the publicity which was given to dentistry as a career by the sittings of the McNair Committee, is that the number of recruits increased very strikingly, and we understand that those who came forward are of high quality. There would, therefore, seem to be considerable room for increasing the number of recruits by more publicity as and when more places become available.

3710. Have you any fresh evidence or views on the number of dentists that will retire later this year?—We have no precise information, but we do know, of course, as the Commission will be aware, that the age structure in the dental profession is rather abnormal at the moment: that there are a considerable number in the higher age ranges who obtained admission to the Register under the 1921 Act, and that it is possible that there may be a rather abnormal number of retirements later this year when they have achieved ten years' superannuable service. But the demand for dentistry is very great and that itself may keep a number of them in the profession, at any rate part-time.

3711. You say, Dame Enid, that the demand for dentistry is very great, but it has been a demand that has been influenced by Government action several times in the last ten years or so?—Yes, that is so.

3712. And that would seem to be a factor that has borne particularly hardly on dentists that, by something quite outside their own control, the Ministry or Parliament, by imposing charges, has suddenly reduced the earning possibilities of dentists by reducing the demand.—It would be fairer to put it this way. The action of the Government, after an initial direct reduction,

has resulted not in a net reduction in demand but in a shift of demand. The number of cases treated by dentists has gone steadily up, but what has happened is that there has been a very marked shift from the older type of patient to the young patient—to what we call the priority classes, the young people under 21 and the school children. The last Government measure of introducing a charge for dental treatment was explained when it was introduced as being intended among other things to produce that result, that is to concentrate treatment on the classes who were thought to need it most.

3713. You see, you say in paragraph 26 that the McNair Committee concluded that the root of the trouble might lie in the present *method* of remuneration and its consequences, and recommended a thorough review of the whole system. I would presume that that is at least partly because of the ups and downs in dentists' remuneration over the ten years, and a feeling of uncertainty in their minds that must surely be greater than that in doctors' minds?—I had read the McNair Report as having primarily in mind the astonishing pattern of earnings at different ages, because the McNair Committee pointed out that, as far as they knew, alone among professions, a dentist's earnings began to fall off in this country very sharply after, I think the age was, 45, and that during the last 15 to 20 years of his working life when in all other professions he would expect to be at the peak he was in fact going down rather fast. Figures we have obtained from America show a similar trend though not quite so sharp a fall-off. It appears to be due to the nature of the work, and I had read the McNair Report as meaning that that was one of the prime reasons why they thought that the method of remuneration should be thoroughly reviewed.

3714. Then do you consider in the Ministry that steps should be taken in some way or other to make the remuneration of dentists more even over a longer period of their lives?—We think it is an awfully difficult thing, Sir, because unless it is being done by putting more money into the total of professional remuneration, it could only be done by trying to level out receipts during a man's total life. That is really by making some sort of a levy on him

during his high earning period in order to pay it back to him during later years, and that would be an awfully difficult thing to do. I would not wish to rule it out, but clearly it would be very new ground.

3715. Would you therefore feel that a dentist in that high earning age ought to be earning a good deal more, for instance, than a doctor of the same age on the grounds that he was said to be earning less at later ages?—Yes. You will have seen in the figures I think you mentioned yesterday, which were a quotation from the Minister of Health of the day, that dentists in that high age group were in fact earning more than the average doctor.

3716. That was in a time of extreme shortage of dentists.—There has been a persistent shortage of dentists since the Service came into operation, and I am afraid that that is likely to persist for some years whatever may be done. It was made clear when the scheme was introduced that dental treatment could not be guaranteed because of the number of dentists.

3717. Dame Eaid, you are dealing particularly with this age group difficulty which is peculiar to dentists, but on the general question of methods of payment we heard from you yesterday about the reason for a central pool for the doctors—general practitioners—which was basically that you must be able to estimate accurately how much you are going to pay out in a year, and put forward reliable estimates. It would seem that that particular reason ought to get less potent as time goes on and you get a better knowledge of what it is going to cost. Was that a fair interpretation of what you said?—Yes, Sir, particularly on the professions within the Commission's terms of reference. There are other item of service professions which are subject to unforeseeable fluctuations, but they need not concern us.

3718. I am thinking simply within our terms of reference. It would seem to me that experience shows you were less able to gauge accurately what you were going to pay out on an item of service basis than you ever were on a capitation fee for doctors.—That is quite so.

3719. Why did you not establish a central pool for the items of service payments for dentists in the early stages?

—The basic reason for the present system of remuneration and why I think all systems possible at the moment are incompatible with the central pool is this matter of the shortage of dentists. You see we cannot guarantee treatment to anything like the whole of the population. Perhaps fortunately the whole of the population do not want to be treated, and that is what makes the present position tenable, but as you do not know and as you cannot base any central pool on the total population at risk, it would involve making an arbitrary selection of the number of people on whom you would base your pool, and that really does not seem to be a feasible thing to do.

3720. But the central pool method was primarily introduced to ensure that your total cost was ascertainable in advance—for doctors?—No, I would not say primarily; it had that great advantage, but it was based on the acceptance by the medical profession of collective responsibility for the whole population. The dental profession cannot accept collective responsibility for the whole population.

3721. So you had to adopt other means of bringing the total cost roughly in line with your estimates but always catching up a year later?—One of the difficulties of dealing with the dental service was at the outset the difficulty of putting any reasonable limit to the total cost. But there was also, if I may repeat it, Sir, this very strong wish on the part of the Government of the day to divert the demand from dentures for the older part of the population, which was predominantly what was being done under the general dental service in the early years, to conservative work for the younger members of the population. And in doing that by the methods adopted—with the co-operation of the profession who have entered very whole-heartedly into this—they have been very successful. The change in the proportion of younger people now being treated and the proportion of conservative work now being done in comparison with extractions and dentures has been very gratifying.

3722. But that I presume is based on the relative charges for the particular items of service? You can make one item more or less attractive in relation to the other?—We have not done it

that way, no. We have aimed, as the Spens Committee recommended, at a balanced scale which, with certain qualifications, pays a dentist exactly the same net for whatever work he may be doing at the time. The object of that is not to give any inducement to the dentist to carry out on a particular patient one form of treatment rather than the other. The way it has been done is by exempting from all charges young people under 21 and expectant and nursing mothers.

3723. *Sir Hugh Watson*: What exactly did you mean, Dame Enid, when you said all this was done in agreement with the dental profession? What had you in mind?—I have forgotten now in what connection I made that remark.

3724. You had been telling the Chairman that the Ministry wished to "divert" I think was the word, the volume of time, dental time, taken up by dentures for old people into attending to school children and expectant and nursing mothers and so on.—Yes. I said that there had been a very marked switch from denture work to treating the younger age groups, and that the dental profession had entered very whole-heartedly into this, which they have done.

3725. That may be, but you see, Dame Enid, we were given, unless my memory is quite wrong, a somewhat different picture. The picture painted was a series of arbitrary reductions made with the minimum, if any, of consultation with the profession.—I hope I have not misled you on this. I am not suggesting the dental profession agreed to the reduction in their remuneration. I am suggesting that when the Department, as part of Government policy, encouraged treatment of the priority classes, that in practice dentists have entered whole-heartedly into that, because after all it is a professional point that treatment should be given to the younger people, and that conservative treatment should be given as much as possible so as to obviate the need for dentures.

3726. What was done by the Government was in the first place, when it was seen the cost of the dentures was far greater than had been expected, that 50 per cent of earnings above a certain sum per month were cut, and secondly a charge was imposed for dentures; and

these two things had the effect you mentioned. You mentioned also that one of the objects of the Ministry was to divert the attention of dentists to dealing with school children and so on. That again was done by increasing the rates for dentists working in schools contemporaneously with a cut in general dental remuneration.—It was done by imposing a charge for dentures and, later, by imposing a charge for dental treatment for patients over 21.

3727. We were given to understand that the Ministry offered increased remuneration to dentists providing the school service, at the same time that in fact a cut had been imposed on the remuneration of dentists, as legally laid down in 1948.—Perhaps I ought to explain here the remuneration for school dentists is not a matter for the Ministry of Health. It is, of course, a matter for the local education authorities and departmentally for the Ministry of Education. That may well have followed, but it is not within our direct knowledge.

3728. *Chairman*: When you say the local education authorities, do you mean that each education authority can decide what to pay?—No, I believe it is centrally negotiated; but I ought to be quite clear this is not for our Department, we cannot speak with direct knowledge.—*Sir John Hawton*: It is in fact a matter for negotiation on the Whitley Council on the local authority side and not part of the National Health Service Whitley Council.

3729. But bearing on this question of recruitment, we have heard that one of the main complaints of the B.M.A. is that there has been no alteration in remuneration for a long time. One of the complaints of the B.D.A., again bearing on recruitment, is that there were very many alterations in conditions that were bound to affect remuneration by decisions taken virtually, if not entirely, without consultation. Are not both of those statements true?—*Dame Enid Russell-Smith*: I think, Sir, there are certain qualifications that need to be made. Firstly, where the dentists' terms of service, the dental remuneration, was altered as it was in the very early days, there was consultation with the profession. It was not very prolonged because the type of income which it was then sought to reduce was of an order

which could not be justified, but there was consultation with the profession. Where charges were imposed, that was a matter of Government policy, and it was thought that that must be first announced in the House of Commons and there was no consultation with the profession. But those sorts of changes are of quite a different type and affect general Government finance and are not part of the remuneration of the profession. I am not for a moment suggesting, of course, that there was agreement by the profession to the reduction of fees—that would be asking too much.

3730. *Mr. Gunlake*: When you refer to a level of remuneration which can be justified, I take it you would agree, in considering whether it is justified or not, that one should have some regard to the hours being worked?—Certainly.

3731. What evidence had you at that time?—Of the hours of work?

3732. *Chairman*: Yes.—We had the post facto evidence of the Penman inquiry to which we have referred the Commission in our written evidence.

3733. *Mr. Gunlake*: That Committee reported, I think I am right in saying, on the 3rd August, 1949, prior to which date dental remuneration had twice been cut, firstly on the 1st February, 1949 and secondly on the 1st June, 1949?—Yes.

3734. Those two cuts were made. At that time you had not had the Penman Report?—No, we had not. If the Commission wished to go into this we could supply figures showing the average earnings during those six months. That is for the Commission to decide; we have got them.

3735. *Chairman*: One of the questions we were going to ask was whether we can have some of the figures of average earnings at this time. The figures we have do not start quite early enough, and maybe the figures of earnings would explain some of the things that did take place, so we would like those. In the factual memorandum you give us information only for the years 1951-52 onwards, and it would be interesting to know how much was in fact paid in the earlier years from the inception of the Service. You see Spens reckoned that dentists should be able to earn so much in the light of so many chairside hours per week, which they thought was about the maximum a normal dentist could do

continuously within a certain age group—there are all sorts of qualifications. Was the scale wrongly calculated?—The scale was wrongly calculated, and the hours per week which Spens recommended while no doubt theoretically desirable were found to bear very little relation to what was happening in practice under the conditions of practice in the early days of the National Health Service.

3736. They were working overtime on what Spens considered was a reasonable amount of time?—They were working more than what Spens considered appropriate, but Spens had no factual evidence before him as to what hours were being worked. This was a theoretical assessment, as we understand it, of what it was desirable for dentists to work. It was found in practice they did not work only those hours, even when remuneration was on a basis which would have enabled them to earn the full Spens income in those hours.

3737. I would like to come back to a question I put earlier. Admitting always that Spens had very little information—he was exploring unknown country—if there was ever a time for a central pool, is it not then so that the dentist who works hardest gets a larger share of the normal pool, until you have got some rough idea of what the real volume of work is?—If I may put it this way: you could only have produced a central pool in those circumstances by saying we will provide so much for dental treatment and when that is exhausted we will pay no more.

3738. Is that not what you do for the doctors?—No, because the population—the demand—is known. We attach a known fee to a known demand. In the case of the dentists all we should have known was the fee. If we had paid a fixed fee out of a limited pool for an unknown demand, we should have come to the end of the money and then there would have been no more treatment.

3739. That depends whether, as I believe you do with the doctors, you pay a fee that does not exhaust the pool and have a supplementary distribution of what is left at the end.—But you see, on an item of service basis and being unable to cover the whole population I do not see how you could have done it other than on the basis of standard fees. The

difficulties of accountancy, going back over all the bills adding a little *pro rata*—leaving the dentist in complete uncertainty as to his final earnings—would have been very great.

3740. On the other hand something like that might have avoided the sharp fluctuations that took place in the earnings with so many changes, which the dentists have submitted to us so very strongly as being a matter that has affected confidence among the profession.—Given the lack of knowledge of timings and hours and demand that existed at the time when the system of remuneration was fixed, I do not believe that any system could have avoided subsequent fluctuations. There was simply not enough known about the extent of the potential demand or the way in which dentists would react to it.

3741. Would you feel, Dame Enid, that this is enough in the past now to avoid any reason for recruitment to the profession being influenced by histories of past unilateral actions?—Certainly I would. I would think by now, while one cannot give any guarantees for the future, that we do know a great deal more about the way in which dentists do their work and about timings and hours. We know a great deal more about demand, and we have invented measures for keeping the demand within reasonable limits in relation to the size of the profession.

3742. You see, Dame Enid, we are asked to decide what dentists with a wide spread of incomes should earn, and if it is going to be worked for instance by the present system of items of service, do you feel confident now that you can establish scales for items of service that will produce about the spread and about the amounts that we may decide should be desirable?—I am confident that we can produce scales which will produce about the average amounts. I am not confident that we can necessarily achieve a spread, because on the basis of items of service the spread depends so much on the capacity of the individual dentist, and it is a form of work which seems to depend so much on manual dexterity.

3743. Mr. Gunlake: You said just now that under conditions which existed at the time the Health Service was set up—with so much lack of information about dental timings and so on—you thought no system of remuneration could have been set up which would have avoided subsequent

fluctuation. There was such a fluctuation on the 1st January, 1949, when the scale of gross fees payable to dentists was reduced, was it not, by 20 per cent. If the dental expense ratio is something like 50 per cent, that meant a cut of something like 40 per cent in the dentists' personal remuneration?—The dental expense ratio has been established comparatively recently at 53 per cent, I think it is. I think it is a proper deduction that it could not have been anything like that ratio on the previous scale of fees, because if it were it would later have been found to be higher.

3744. Let me put that point another way—it is not material to the point I am making. A reduction in the scale of gross fees does not have any effect on the individual dentist's outgoings unless he in turn cuts salaries of assistants?—No, it does not.

3745. So you would agree that a reduction of 20 per cent in gross fees does mean a cut of a good deal more than 20 per cent in the dentists' scale of personal remuneration?—Yes.

3746. You regard that as not a very severe change?—I think our subsequent investigation, which showed the expense ratio was still not much over 50 per cent, shows that the result of that cut was to produce roughly the object we aimed at originally when we took the expense ratio at 52 per cent.

3747. You mean until that time the system had not produced the result you intended but it did after that change was made?—Yes, I do.

Chairman: Do any of my colleagues wish to ask any questions on the next section of this memorandum, section 5?

3748. *Mr. Gunlake:* May I ask one question? This is a section which deals with the question of the load of work, and there are some very interesting statistics there about the load of work in the hospitals, and in Table 2 on page 703 that is compared with the change in the number of consultants. Could I ask how part-time consultants are dealt with in those statistics?—*Sir John Hawton:* They are counted as units—individuals not accreted into a number of full-time equivalents.

3749. *Professor Jewkes:* I have one question arising out of paragraph 29. I gather the general view of the Ministry

is that with lists at their present size there is no reason to believe there is excessive work thrown upon the general practitioner, and that is indeed the suggestion that was made to us by the B.M.A., too. But I have still got a feeling that if one takes a general practitioner with the maximum size of list, 3,500, and then does the little sums that can be done by looking at paragraph 29, you do get a suggestion which runs the other way. The figures I have in mind are these: a list of 3,500 with five consultations a year gives you 17,500 consultations a year. It is suggested here that consultations on the average last ten minutes, which gives the result that there will be about 60 consultations a day—if you assume that the doctor is working 300 days in the year. This finally leads you to the result that he will be working ten hours a day for 300 days in a year. That seems an awful lot.—*Dame Enid Russell-Smith:* I think, Sir, it would be a mistake to apply these average figures to the rather exceptional practitioners who are able to manage the large lists. The list of the maximum size is by no means common. It is only in rather special circumstances and perhaps rather special doctors who can manage those lists. They must in the nature of things be extremely good organisers and I do not think that one can draw deductions based on average data applied to these maximum lists.

Professor Jewkes: I see, thank you very much.

3750. One further point. Table 3 on page 706 shows the number of cases per dentist per annum, and the cases, of course, are a compound of courses of treatment and cases of emergency treatment. When you work out the sum there it suggests that with the 1,080 cases per dentist per annum the average per day, on my 300 days' work per year, comes to about three. But, of course, the course of treatment itself may have changed in meaning over this period, may it not?—The course of treatment has changed; it has varied very much over this period. At the outset there was a far bigger proportion of extractions and dentures in relation to conservative work than there was at the end of the period.

3751. I have heard it said—I do not know whether it was before this Commission—that since the imposition of

charges for dental services there has been a tendency for the course of treatment to be lengthened, that the patient has more items done in one course of treatment than he had before.—There is an inducement to the patient who needs attention to have everything done, and that was done deliberately because it is very wasteful of dental time for a patient to go to the dentist and refuse to have done something to a tooth which could be saved, and which is going to take a lot more work and money to put right later. If the patients pay the maximum charge they do not pay any more for whatever treatment is necessary, so that there is—and there was intended to be—a strong inducement to the patient to have done whatever is necessary. And that again is fully in accordance, as we understand it, with principles of good dentistry.

3752. That is exactly the point I had in mind: that if in fact you have been encouraging longer courses of treatment—in fact more items in each course of treatment—then these figures of cases per dentist tend to under-estimate the increase in the amount that each dentist is doing per annum.—There is a big offset there, and that is the reduction relatively in dentures.

3753. Yes.—Because the denture case is the longest—well, I do not say it is the longest of all courses—but it is a long course. This would do a great deal to offset the fact that there is more conservative work being done.

3754. And you would think, setting one thing against the other, probably this series of cases per dentist is a good indication of changes in the amount of work?—Yes, I think probably there has been a slight net increase in the amount of work due to improved methods, because after all dentistry is a living thing and a progressive thing, and due perhaps partly to the increasing proportion among dentists—which is now beginning to make itself felt—of young men, with the corresponding speeding up.

3755. Just one further minor statistical question, Dame Enid, on Table 6, on page 708. This is the table showing the numbers of medical and dental staff and this is, by now, quite an old mystery to me. It is this. We know that there is a rather serious surplus of senior registrars but these figures show that although

there may be a surplus, the number has fallen by 24 per cent over the period. On the other hand, we are often told that there is a rather desperate shortage of registrars, but the number of registrars has, in fact, increased by 68 per cent over the period. I have no doubt there is a good explanation of this but no one so far has really explained it to me.—*Sir John Hawton*: Perhaps I might intervene there. I cannot explain the second part as to the ordinary registrar. I think the obvious explanation to the first part is that one of our difficulties was that there were more senior registrars than could be absorbed in consultant posts and that is still a difficulty, but they are being absorbed and so one would expect the figure to be falling. I can answer that part, but I am afraid I cannot explain the figure for the ordinary registrar at all.

3756. It is such a very large percentage increase.—Yes, it is. I am afraid I do not know the reason.—*Mr. Graham*: I think one of the factors is that in accordance with the Spens recommendations the registrar was originally conceived of as a training grade like the senior registrar, whose numbers should be related as closely as possible to the prospects. At a later stage that strict concept of the registrar was dropped and the hospital authorities were permitted to employ registrars in accordance with the staffing requirements and not the career prospects.

Professor Jewkes: It points really to some sort of change in the function of the registrar.

3757. *Chairman*: Perhaps that brings us now on to the section beginning in paragraph 47, and going on for some time, on which, Sir John, we said a few words last night. You explained why there were certain things you could not elaborate very much at the moment about the senior registrars, but there are some other things which we want to take up. The B.M.A., when they gave us evidence, which I am sure you have seen, made the very definite statement that the S.H.M.O. grade had been exploited by the authorities, who were using S.H.M.O.'s to do consultant work and paying them less. It is in paragraph 144 of the B.M.A.'s preliminary

memorandum and the sentence in particular is short:

"The Council believes that the grade has been exploited."

Now, whether that is so or not, it is again an extremely important matter if anybody in the profession should believe it is so if it has not been so. Could you give us any views on that?—*Sir John Hawton*: We do not think it is generally proved that it has been exploited in any way. There may be cases, of course, there are bound to be, where a S.H.M.O. might be a consultant and has been missed. He has his opportunities to draw the attention of that to the Hospital Board concerned and to us. But I have, if I can find it, some little evidence here. This is perhaps relevant. The suggestion is that the S.H.M.O. grade is exploited and used because it is a little cheaper than the consultant grade?

3758. That is what the B.M.A. imply.—The facts are that between 1953 and 1957 the consultant strength has increased by 9 per cent and the S.H.M.O. by 4 per cent which would rather point to the fact that there has not been a swing towards concentrating on the S.H.M.O. at the expense of the consultant.

3759. Yes. I know this is a difficult one to deal with precisely.—That is relevant.

3760. I do not think it was suggested there had been a swing. I do not think it was suggested that exploitation had increased but I rather read it that exploitation was continuous in the B.M.A.'s view.—Is it not still relevant, Sir, that if that is true how does one account for the relatively larger increase in the higher paid consultant than in the S.H.M.O.—more than twice the rate of increase?

3761. *Chairman*: Yes, the figure is rather paralleled, of course, in your Table 3 to which Professor Jewkes was referring. That shows that continuously consultants had gone up more in proportion.—Anyway, I can give the Commission an assurance there is no desire to exploit the S.H.M.O. grade and any suggestion will always be gone into with the profession, and is from time to time.

3762. Is it anticipated, subject to what we may say, that the S.H.M.O. grade or something like it will continue as a

permanent feature?—That is essentially part of what we were talking about yesterday: what is the proper structure for the future which affects the consultant, the S.H.M.O., the senior registrar, and which could affect any new grade created? But it must be looked at in one picture of the best structure and, therefore, the best career prospects, bearing in mind that to regard, as Spens did, all these grades—he did not mention the S.H.M.O. grade, but the other grades—as merely training grades does not, in our view, fit the needs of the hospital service. There is need for an actual career person who is not merely there for training for a limited period.

3763. Now, again on the question of the senior registrars, it has been made pretty clear to us from many quarters that it is not so much the question of the actual level of the pay as the insecurity of tenure which really matters to them; the fact that they are only on a year's tenure or sufferance after they have completed their period. Would you agree with that?—I think that is really a material point that you have more senior registrars than can be absorbed quickly into consultant posts, that they have been notionally regarded as in a training grade, that theoretically after four years, therefore, if they have not got a consultant post, they are finished. We have had artificially to keep them going both in their own interests and because the hospitals need that kind of work, and there is no security at all in that grade after four years. That is one of the essential problems in the structure of hospital staffing; that, I think, is one of the most important things we have to tackle.

3764. In paragraph 56 there is a reference to the rise in the number of senior registrars after the war as being due not only to the desire to absorb demobilised doctors but also to the staffing needs of the hospitals. Does that imply that senior registrars were at that time recruited deliberately beyond the numbers that might reasonably be expected to occupy consultant vacancies?—I must not answer that too definitely because, of course, I do not know the inside of hospital running in a medical sense, but I think it is true that more were recruited than could possibly have been absorbed in consultant posts not only because of people from the war but because, as I say, experience has revealed

the need for a career post in the specialist world below the consultant, not a training post.

3765. Yes. Therefore it would be important if there were more senior registrars than could ever become consultants that there should be at least the opportunity for some of them to have posts of indefinite duration?—While we are trying to find a better structure we are, in fact, keeping them on year by year, which is not a very satisfactory solution to my mind from their point of view.

3766. We have had suggestions about part-time appointments for registrars and senior registrars. What would you say about that?—I have here some notes on that subject but I really think you should obtain evidence from medically qualified people on that. You see the advantages of a part-time registrar or senior registrar are now not an administrative problem. I think it would be a little unfair to the professional witnesses if anyone like myself expressed a view of what was right or wrong.

3767. Yes. You have no particular administrative objection in the Ministry to that suggestion if the medical reasons seem to justify it?—No. I am in this difficulty on all of this: I will do my best to help you but I am sure the professional people will understand me that it would be wrong and a little presumptuous if a lay civil servant was too dogmatic about how you organise the professional or clinical staffing of a hospital. That does not mean that there are not things which I can perhaps properly answer but there are some essentially which are for them. I hope you will agree.

3768. Yes, I think that I am prepared to leave that. We have had considerable comment on the matters of the house officers and on the question of charges made to them. They have been widely criticised. What would your view be, Sir John? Would it be practicable or wise to abolish them as separate charges and instead to take account of the value of board and lodging in fixing the salary of house officers and to pay a lodging allowance to those who live out? Or would that not be a good thing?—At the moment the important point is that the charge made for board and lodging for those resident is below the cost price. In other words, it is,

as it were, subsidised. It is difficult to understand, therefore, how they would get any advantage out of this unless you altered the whole of their remuneration and then did something to offset that by charging the real cost. I should not have thought it would have been an advantage to them.

3769. It has appeared to us to be rather a psychological point, this question of charges. One is assuming that whatever the total remuneration it must take some account of whether board and lodging is free, subsidised, or is paid for in full. But within that, I suppose partly because of previous practice, there has been a feeling that a charge is unwarrantable by some parts of the profession.—It is, of course, not confined to the medical profession. I mean it is applied to the nurses in a hospital and, indeed, there will be an immediate repercussion in the changing of it in the whole of the nursing world.

3770. On the whole you feel that the present system is better?—Actually I should have thought the present system was better.

3771. Another point that has been put to us is that consultants are tending to achieve their status at a much later age than Spens envisaged. Part of that no doubt is due to National Service which will be disappearing as a factor but would you like to comment on whether you think the ages Spens suggested are likely to be achieved normally in future or that one should bear in mind that people will become consultants rather later than at 32?—I have no idea how it will develop. It must have been influenced by the war partly and, of course, the age distribution with which we have been dealing over the ten years which may alter; but I have no idea whether it will become a younger age or a later one eventually.

3772. You agree it is a factor to be taken into account in fixing remuneration as to whether a man can be expected to be in the 40p income bracket for, say, 25 years or 30 years?—As long as one has reliable information on it, it is obviously a factor.

3773. Yes. Can we come to this question of the whole-time and the part-time consultant. I think in one of the many Reports, it is probably the

Guillehaud Report, it was urged that there should not be any particular inducement to a consultant to become part-time as opposed to whole-time. At the present time would you consider that there is rather too much inducement or rather a premium on becoming part-time?—The factual evidence on that is that there is a tendency for people continuously to prefer to change to part-time, so presumably it has advantages.

3774. Is it affecting the operation of the service at all from the point of view of the patient?—No, from the point of view of the patient I should say no. As far as one can tell, broadly speaking, the consultants are there. I was thinking of the question of fairness between whole-time and part-time which is, I think, the main criticism.

3775. Do I gather from what you say that very often the 9/11ths consultants are there for as long as they would be if they had been whole-time but have chosen that method of having freedom to operate outside and freedom of being their own masters?—They have chosen it no doubt for many reasons. I am only putting this as a question. It is open to question whether the weighting of the sessions, that is paying rather more than the actual session fee is now any longer justified. It is a question no doubt you will be considering. It is also, I think, a part of a much wider comparison between the two, such as domiciliary visits and expenses. The Commission may feel, and here I am only putting it forward as a thought, not a strict conviction, that it is a little strange that a person should be paid for a half day's session and that his journey from home to the hospital should be counted as though he were working clinically in that session; that his journey should be included in it as well as his receiving in the ordinary way travelling expenses. That is one of the kind of points which I think are under discussion and you will no doubt want to decide whether it is justified. It is certainly unusual.

3776. I thought you had suggested rather more firmly than that somewhere in this evidence that perhaps the weighting which was reduced on a previous occasion was about due to end. Was that not so?—I think a lot of people would feel that the time has come when

if somebody chooses to be a part-timer and take payment by sessions, the payment by sessions should be a perfectly simple and straightforward thing and should not have these additional perquisites, if I may use the word, such as the one I have mentioned about travelling. Indeed, some people would go further and say it is an extraordinary thing, perhaps not known in many professions, that the payment for a session, a half day, is not dependent on attendance for that half day but is based on an assessment of whether the half day would be needed by an average consultant to do that job. So that if a consultant can do the thing in less, he can be one up, and he is not required to be available on the premises for the half day for which he is paid per session. That, again, it seems to some laymen, is an extraordinary fact.

3777. You know that there are differences in the income tax treatment?—I know those too, but I am not an expert on that.

3778. Would you like me to turn to Sir Thomas who may produce some justification?—*Sir Thomas Padmore*: I do not think we can attempt to speak for the Inland Revenue and the mysteries of the income tax law. I think if you want to go into them you really must approach the Inland Revenue. I am neither qualified nor would it be proper to speak for them.

3779. Taking all these different things together, including income tax treatment, would you feel, Sir John, that there was any reason why a whole-time consultant without a merit award, leaving that out of it, should be in total enjoying materially more or less remuneration and amenities than a part-time consultant?—*Sir John Hawton*: I can answer definitely that I can see no reason why a part-time consultant should be better treated than a whole-time consultant.

3780. Or worse?—Or worse.

3781. Provided that he is using his odd elevenths for doing other work?—Yes. The fact that he is in private practice does not, to my mind, entitle him to be in any way better treated than the man who is whole-time and has no private practice.

3782. Would your view be that if we find from the questionnaire which has gone out and has been so very well

answered, that the nine-elevenths part-timers are doing much better or much worse—again leaving out the merit award elements—than the whole-timers, that is something we should try and adjust?—Personally I should think so.

3783. Yes, *Sir Thomas Padmore*: If I may just say this while we are on the question of what *Sir John* said about the possible anomalies that may have crept into the system of remuneration in the last ten years and the various things that sometimes strike a layman at first sight as being a little strange. I think it is fair to mention this question of domiciliary visits. It may well be that the Commission will want to look at a system which, as I say, at first sight does appear a little odd. For instance, if you take the case of a full-time consultant who is paid to do his job in the hospital or as one would suppose, when the need arises, in the homes of the patients, it seems a little odd that he should get additional remuneration—as it were, almost accidentally—by reference to the distribution of his time between the hospital and the patient's home. One would have thought that the right thing to do in those circumstances was to fix a proper level of remuneration for the individual concerned to do the job for which he was paid wherever it might arise and, in particular, as between those two places, his headquarters, the hospital, and the home of his patient. I think the same considerations to some extent apply in the case of part-timers.

3784. For the part of the time for which they are working within the service?—Yes.

3785. At any rate you do not see any particular reason for requiring eight unpaid domiciliary visits per quarter for the whole-timer but paying for all the domiciliary visits of the nine-elevenths part-timer?—*Sir John Hawton*: No. It started with no domiciliary payment for the whole-time man on the basis which *Sir Thomas* has advocated. But the effect—never mind the justification—of differentiating in that way between him and the part-timer was such that we thought that he ought to be given some of the facilities of payment for domiciliary work and the eight free visits were, as it were, a concession to his being whole-time. It was really done

because there was an anomaly between the two, and it had an adverse effect in the Service because a general practitioner would quite naturally, if he was aware that there would be payment in one case and not in the other, tend not to bother or to call out the man he knew would not be paid. To that extent it had an effect on the Service. That was why we made that adjustment. I am not dissenting in the slightest from what *Sir Thomas* has just said, I can see a little more difficulty in applying it in the part-time case because if the remuneration part-time is based on including domiciliary visits when are those domiciliary visits included? Is one unable to have the advantage of that consultant when it does not happen to be, say, a Thursday morning or a session when he is working? I can see a difficulty there. But if it could be done, of course it would be cleaner to get a proper rate of remuneration to cover the responsibility for the patient no matter where he is.—*Sir Thomas Padmore*: I cannot help feeling that what has happened, as *Sir John* has mentioned, is that the change between part-time and full-time does look at first sight to be the ending of one anomaly by adding another. It is very difficult to see why a part-time consultant who carries out a domiciliary visit during time for which he is paid to be at the hospital, should have additional remuneration because of the almost accidental circumstance that he has to go and do his job somewhere else. If I may say so, somewhat flipantly, I should think it very odd if I were paid something extra for coming and doing my Treasury duties in this room instead of in the Treasury Chambers.—*Sir John Hawton*: Especially if one were paid travelling expenses in addition.

3786. I suppose there is some difference between the different specialties. Some are much more likely to be called out for domiciliary visits than others.—Obviously I think so, yes.

3787. Therefore a certain whole-time consultant will have access to opportunities for earning more than other whole-timers because he happens to be in a specialty that makes him go out more often.—So far as domiciliary work is due to emergency and calling someone out to an emergency, it is bound to vary obviously

between a surgeon and a specialist in dermatology where there is much less likely to be the emergency that cannot wait until morning. That is bound to happen.

3788. Do you generally accept the view which has been put to us, I think it was part of the Spens basis, that all specialties are equal in status, leaving out again the question of merit awards? The possibility has been put to us that some, because of the extra discipline, extra study and so forth needed, may be worth more than others?—Yes, I think obviously one must have personal opinions about the varying values of the varying degrees of skill of different kinds of specialty but for the purpose of remuneration we could not evolve a scheme, I think, other than a broad band scheme which covered those who reached the same level in any specialty in the same way.

3789. Do you definitely regard the consultant who chooses to be part-time and the consultant who chooses to be whole-time in any specialty as being equivalent?—Yes.

3790. *Mr. Gunlake*: Do you know, Sir John, in the days before the Health Service, if there tended to be any differences in this respect? As a layman I would have thought that the strain of neuro-surgery or thoracic surgery would be more severe than the strain of other surgery. Did those specialists demand higher fees?—I have no figures of what the fees were and no doubt they varied with the individual. Of course there were no general public service payments in those days. But when you say as a layman you would have thought in those two examples there was a difference, that is what I meant when I said that each of us has a personal opinion; I do not think you could translate that into an organised publicly paid scheme.

3791. *Chairman*: A great deal of the next section of your memorandum deals with merit awards. I think we have really covered that. We see your views. I do not think we need ask you very many questions, except on the question of secrecy. Would you care to express any views—I hope you would—on whether on the whole that is desirable or not? If so, to what extent?—My own view is that I do not feel very strongly about it at all, but it was adopted

on the grounds that it was thought a little unfair that the knowledge of their merit award might, owing to misunderstanding of its meaning, unfairly attract custom, if I may use that word of the profession, to individual doctors compared with others. It was thought it might be an unfair influence; but I do not personally feel very strongly about it. The policy of the Ministry so far is that it is on the whole better to leave it at that.

3792. As a general system you are in favour of the merit award system?—When you say in favour, we cannot think of any other method of achieving the object of giving higher remuneration in the case of particular specialists; we cannot think of a better system. It is in itself, as everyone would see, a rather extraordinary system in the sense that it depends on the advice of a committee picking individual people and advising the Minister. It does not depend on posts. But we have thought a lot about it and so far we cannot think of a better system. Whether it will be affected either in its quantity, its nature or even its abolition by a completely different hospital structure, there is a point for the future.

3793. *Mr. Gunlake*: Have you given any thought, Sir John, to any possible ways of rewarding distinction amongst general practitioners?—It has been suggested but it has never been adopted or agreed. I am not advocating it.—*Dame Enid Russell-Smith*: Nobody has ever been able to think of any criteria on which you could base such a system.

3794. *Chairman*: Do you really believe, Dame Enid, that the present criterion of what was described by some of our witnesses as "head hunting" is an adequate one?—You mean the capitation fee system?

3795. Yes.—I think that as a system it has its disadvantages but we have not thought of any other system which has not greater disadvantages.

3796. *Sir Hugh Watson*: When you say we, that includes the medical profession?—That includes our constant consultations with the General Medical Services Committee.

3797. *Chairman*: Have you been able to think of any other system which has greater difficulties?—We have thought

of one which the medical profession consider has far greater disadvantages and that is a salaried service.

3798. Yes, that may be a thing that we shall have to consider. But do you think that really this present system of capitation fee and remunerating doctors purely on the number of people on their lists does give the right doctors the highest remuneration or not?—*Sir John Hawton*: I would have said if you mean universally, of course not, but what system would? On the whole it gives the doctor the incentive to look after patients, to make his list up. The alternative, leaving out a salaried service which at any rate is barred by statute, would be some kind of payment per visit or per item of service. That is open to all kinds of obvious abuses and we think that paying the doctor for the number of people who choose to go to him and who, you must remember, are free to leave him and go to someone else whenever they want to, is probably as fair a system as you can get. Of course it is not perfect, of course there will be abuses.

3799. We have heard from Lord Moran, and I do not think it has ever been doubted, that the A and B awards very largely choose themselves as being obviously the meritorious people, but there is always a certain amount of difficulty in deciding who exactly should fit into the C vacancies. Might it not be the same in any one town or in any one area looked after by certain doctors, that certain doctors in certain areas are known by the Executive Council to be the best ones, as doing the best work?—I doubt whether the Executive Council would be the body to know it. You see, in the case of the consultant you have got a specially set up committee which devotes an enormous amount of time ascertaining through direct contacts all over the place what the qualities and the claims of the consultants are for awards. But it would be putting, I should have thought, a rather thorny function on a local Executive Council which is after all very largely a lay body, to say that in this area Dr. So-and-So is obviously an outstanding doctor. I mean, to rely on that and then pay more as a result of it might lead to a lot of unfairness to others who had not attracted the notice of the Executive Council.

3800. *Sir David Hughes Parry*: Could there not be a special body in each area

set up for this special purpose?—It would mean setting up 138 special bodies in 138 areas and I do not know how they would really set to work in general practice at all.

3801. *Chairman*: Sir John, have you any knowledge at all as to whether the doctors in general practice who get the bigger incomes now are largely the same doctors who got the bigger incomes in the old days or whether it has gone the other way round?—*Dame Enid Russell-Smith*: I think it is a fair assumption that they are the same. You mean before the Service was introduced?

3802. Yes.—I think it is a fair assumption that they are largely the same doctors but, of course, there are far fewer of them now because the average list has steadily gone down and the numbers of doctors with very high lists have been reduced.

3803. Yes, but it was suggested to us, for instance, that some of the residential districts with a lot of elderly people used to be the profitable districts because payment was on an item of service basis; and now those particular districts and those particular practices, had become very much the less profitable ones now on a capitation fee basis. Have you any knowledge as to whether there has been a considerable switch as between individuals in almost every district?—I am sorry, I misunderstood your first question. I was replying in terms of the old Health Insurance scheme and as regards insurance practice, I am sure it obtains that they are much the same men. As regards private practice it is thought, as you say, that a number of the residential districts used to be more profitable than they are now.

3804. Do you consider that the best doctors then used to live in the residential districts and have moved now to other parts of the town or district?—We have no knowledge of that but what we have done is to try to make the medium size list, which is the sort of list you will get in the residential areas, relatively more attractive than the very big lists.—*Sir John Hawton*: Also, if I may say so, there is no reason to assume, although it may be true in certain cases, that the best doctors in the old days—that is best in terms of skill—were in the higher paid residential areas.

3805. No, I think that is quite true, Sir John. But purely in terms of remuneration, if the present test of merit is who can have most heads, in the old days it was on the basis who had the most from item of service payments.—That has been compensated for now by putting this weighting on to the capitation, the payment per head, favouring the people with the smaller lists, the medium lists.—*Sir Thomas Padmore*: There cannot be much reason to suppose, can there, that the higher merit coincided more nearly with the higher remuneration before the Health Service existed than it does now?

3806. It has been suggested to us that it did because patients then went of their own free will and now they have rather found themselves with these sudden changed circumstances.—*Sir John Hawton*: But the patient is not always a good judge of the medical profession.

3807. On that we will agree. At any rate you have not at the moment in sight any suggestions about how to reward or encourage merit among general practitioners. This was really Mr. Gunlake's starting question, how to reward merit among general practitioners except by capitation fee, just moderated by the loading system.—*Dame Enid Russell-Smith*: There are other things as well, for instance, a number of extra payments such as maternity services, and one might presume that perhaps a man who does maternity work is providing an extra service which some of his fellows are not and deserves extra reward for that purpose.—*Sir Thomas Padmore*: May I say, too—on behalf of the Treasury because of our concern with remuneration of the public services generally—that we agreed with, and indeed are parties to the note which has been put before you about distinction awards. It is in a sense from our point of view a very curious system. I know of certainly no other public service in which remuneration is not linked to the post which a man occupies, and therefore this present system of distinction awards is quite unique in the public service. But we take the view, as do the Health Departments, that it works, and it appears to be on the whole acceptable to the profession. It is very difficult to think of any alternative that would be likely in the circumstances of this branch of the medical profession to be more satisfactory than this and therefore we would

say go on with it, odd though it may be, or at any rate unique though it may be, because it does appear to suit the rather peculiar circumstances. We would have thought that any attempt to extend the system to general practitioners, would be likely to encounter even bigger difficulties in the circumstances of general practice than the system has encountered in relation to the consultants. We should be most hesitant to advocate or indeed to contemplate any extension of this, as I say, unique system. We should be very doubtful of the good sense or usefulness of attempting to extend it further.

3808. *Sir Hugh Watson*: Sir Thomas mentioned the question, as did Sir John, of the possibility of these distinction awards being attached to posts rather than individuals. I think, as the Commission understands it, that is not possible in England because no one consultant is under any other consultant.—*Sir John Hawton*: First let me make it quite clear I am not advocating they should be attached to posts.

3809. No.—I just mentioned one of the possible alternatives. The whole point is that at present they select individuals where they find them no matter what kind of specialist work they are doing. Attaching the award to the post would not have the same effect.

3810. As Mr. Anderson is aware, in Scotland the position is somewhat different because there you definitely have a surgeon in charge of a hospital.—*Mr. Anderson*: In charge of a unit: so that if one were in fact thinking of an alternative system whereby payment was related to responsibility there would in Scotland be at any rate the makings of a basis.—*Sir Thomas Padmore*: Though on the face of it one would have thought that would not form a basis of discrimination for anything like the size of the bigger distinction award, since the consultant in charge of a group and the others working with him are very nearly on the same level.

3811. *Chairman*: When you mentioned the size of the bigger distinction award, is it not less, relatively, in comparison with basic salary than was originally proposed by Spens?—Oh, yes, I was not saying there is anything wrong with the size. What I was saying

was that if you went over to a system of attaching them to a post it would, I should have thought, be very difficult to justify a differential as big as that based on the difference of being surgeon in charge of a department in a hospital and being one of the surgeons who was working as his assistant.

3812. *Professor Jewkes*: And incidentally maximise friction because these different consultants would be in such close propinquity.—Exactly.

3813. *Mr. Gunlake*: May I ask a question on the system of distinction awards. In paragraph 60 of your memorandum you said the total amount of these payments on a full-time basis would exceed £2½ millions per annum, but is in fact less to the extent that many of the recipients are employed on a part-time basis—that is because the number of persons getting awards is irrespective of the proportion doing part-time or whole-time service. If it does cost less than £2½ millions may we know, in fact, how much it does cost?—*Sir John Hawton*: I do not know whether I have that figure here but may I provide it to the Commission? I have not got it with me. I will send it in.

Chairman: Yes.

3814. *Professor Jewkes*: There is another question, Sir John, on a matter mainly statistical, on paragraph 65 (c). When Professor Bradford Hill was undertaking his census of earnings for the purpose of the Spens Report on consultants, using his own definition of consultant he found 1,700 of them and for those 1,700 he produced statistics of earnings. He appeared to imagine that the 1,700 represented substantially all the consultants in the country. It comes, therefore, as a bit of a shock to discover that in 1949 there were 5,600 consultants. One of the important points that arises here is that the Spens Committee in recommending merit awards spoke in terms of percentages. They said that 33 per cent. of the consultants should get merit awards. The question is if the Spens Committee thought they were talking about 1,700 people that is a very different suggestion from the suggestion that would have been made if they thought they were talking about the possibility of 5,600. Have you any light to throw on this particular point?—Of course I cannot go back and know

exactly what happened in the Bradford Hill case but I think it is true that his figures did not include all people of consultant level in the local authority hospitals; they were mostly people in the voluntary hospitals. I am not sure of that but I rather think you may find that is the answer.

3815. *Chairman*: Were the Ministry surprised, Sir John, when they found that they were going to be paying awards for special merit and distinction to a total of something like 2,000 people, 34 per cent of the 5,000 people?—No, as the thing developed it became apparent that would be the size of it.

3816. That was not a particular surprise?—Not a particular surprise. We did not know it before we started but it evolved quite reasonably and naturally.

3817. *Mr. Gunlake*: Perhaps by that time the Ministry had ceased to be capable of surprise.—I think we are sometimes.

3818. *Professor Jewkes*: Does it follow from this that when the National Health Service was started a considerable number of people were dubbed "consultant" who would not have been so regarded before the National Health Service?—I come to that difficulty again. I really cannot as a layman say whether a person is wrongly called consultant against what you are suggesting as a possibility. You have the other complaint put before the Commission—that people are being wrongly called Senior Hospital Medical Officers who should be called consultant; but only a professional man can judge whether the designation is right in any particular case.

3819. *Chairman*: Yes, but the question really means was there envisaged at the time of the Spens Report about 500 or 600 people who were of outstanding merit and distinction and whose contribution to medicine deserved something above the normal top consultant scale or was it envisaged that there were 2,000 of such people? That is really the question and it is particularly material.—No, I am not at all sure from memory going back to Spens, but I should have thought that about 2,000 would have been the result in Spens' mind if he had worked it out afterwards. I realise it has been suggested that was

wrong. We think the number now is about right.

3820. It has seemed that the Spens Report at least bore the first meaning that about one-third of the consultants in any particular major branch would be people who would at some time or other in their career become of outstanding merit and deserve some appropriate recognition. In fact in some of the modern specialties which are very skilled all the consultants will at some time in their career be within that bracket. Is that not right?—No. On your first point I think the essence of the merit awards scheme from the start has not been that about one-third of each specialty would qualify but one-third of the specialists' profession as a whole. It might be very unevenly distributed because a distinction of the kind required might be found from one year to another in different specialties. As to the numbers in the whole profession who can be expected to finish up with an award we are going to try and give you a note of some estimate.

3821. Yes, I think we have seen in the answer to a question in the House of Commons quite recently that, for instance, in mental health the number is very small whereas in general surgery the number at any one time getting it is over half the total establishment.—Yes, I saw that question, of course. But the recommendations come from Lord Moran's Committee and take the profession as a whole irrespective of particular branches of it; and if it works out like that it may work out differently another year.

3822. What I was leading up to myself, Sir John, is that it would seem that the description in the words "outstanding work and merit" and so forth has perhaps been a little misapplied by being watered down. The value of the awards has not been adjusted to the value of money at all and it might be there is a case for awards of a yet higher level to a very small proportion of people who really are notably outstanding. I wondered if you had given any thought to that? Call it, if you like, a super-merit.—We had not thought about it until we saw the suggestion before the Commission but I do not think we should have any particular objection to that method of distributing these awards if

it were to be changed in that way. That is distinct from the idea, I take it, that awards should carry betterment.

3823. Yes. It is distinct from it but it would seem that one of the reasons the award has not gone up at all might be that it has covered rather a wider range of people than was envisaged at the beginning?—Or the alternative, of course, the whole philosophy of it is that the remuneration goes up and the award remains an extra bonus.

3824. There was nothing in Spens to suggest that?—No, but Spens, as I said rather contentiously yesterday, was not intended to apply for all time.

3825. No, but there is nothing in Spens that has any bearing on the operation of this service that can be interpreted as not recommending any change in the value of money of the awards at all?—Not as far as I know.

3826. I think definitely, not even at the beginning.—Yes.

3827. Another point has been put to us by the Medical Research Council. They complain really of the withdrawing of merit awards from non-clinical doctors engaged in medical research, feeling that some of those, including many Fellows of the Royal Society, may well be contributing as much to the advancement of medicine as anybody else. Would you like to express an opinion?—Sir Thomas Padmore: I think this is a very difficult problem, Sir. I think there are powerful and compelling arguments that are quite irreconcilable. It is like the situation you find yourself in when there are very good reasons for paying A more than B and B in turn more than C but there are also very good reasons why A and C should get the same. You cannot find a solution that pays regard to all the arguments. There is, of course, on the face of it, great force in the argument that, I think, was put before the Commission—it has certainly been canvassed a good deal in various quarters—that the medical man who is engaged wholly on research and has no clinical duties whatever may, and in actual practice very often does, make certainly as big contributions towards the advancement of medical knowledge as anybody. Therefore why should the opportunities available of getting to the highest level of remuneration be denied to him? But once you accept that argument, once

you extend the area of distinction awards to medical men who have no clinical duties you are then faced, particularly in the Universities, but not only in the Universities, with another very powerful argument of repercussion. Why should the research worker in medicine be differently remunerated from the research worker in another branch of science or even in scientific work which is of a medical character but which is carried out by somebody who has not actually a medical qualification? If, for instance, the eligibility for distinction awards of the clinical professors in Universities and the clinical teachers generally were to be extended to research workers in the Universities or teachers in the Universities who do not have clinical duties it is really difficult to see where to stop. Why should the remuneration of a professor of pathology, say a man of the highest distinction, who has no clinical duties be different from that available to him if he was doing clinical work; why should it be different from that which is available to a professor of biology and why in turn should that be different from the professor of physics? Before you finish you run round the whole field. I think you are faced with the fact that there are these difficulties at every stage. Supposing that you went to the logical conclusion and said that distinction awards should be available to all teachers, even the arts professor, because there is no point at which you can logically stop; you would be back in square one again because I think the medical profession would be justified in saying that the whole idea of distinction awards is that there should be special remuneration attached to certain parts of the profession because of special responsibilities, particularly the responsibilities for human life and so on that fall to them. I think, therefore, that one is forced to the conclusion that anomalous though it may be and powerful though the arguments against it may be, the only sensible course is to stay where we are and to restrict this unique system of remuneration, to restrict it narrowly to that body of people for whom it was originally intended, that is to say, members of the medical profession, consultants who are discharging clinical duties.

3828. *Mr. Gunlake*: This would in effect, or in principle, preserve the situation which existed before the Health

Service. In those days it was possible for the top flight surgeon or physician to rise to a high income level but not professors of biology?—I think that is true.

3829. Despite which there was no shortage of sufficiently capable professors of biology?—I think that is true too. I think if you keep the line of discrimination, if you like, where it is now you will be keeping it where it has been for a very long time.

3830. *Chairman*: I was just turning up Spens and I could not see on the particular matter of distinction awards that there was any reference there to the responsibility for human life and some of those particular matters. We are under our terms of reference necessarily compelled to compare remuneration received by doctors in the National Health Service with other kinds of doctors so this is something which we cannot ignore. It is quite a complicated question.—Yes. I realise that, Mr. Chairman, but all I am saying really is that I think you have this unique system which, in ordinary terms, applies to specialist doctors who are doing a specialist doctor's job; and I think that insoluble difficulties are likely to arise if you extend it to any other category of people, even including specialist doctors, who are not doing a specialist doctor's job in the sense of treating sickness.

3831. Would you think that this was to some extent a recognition of a situation which existed before the Service where some of the top specialists were earning very high sums outside in private practice including those attached to hospitals?—Yes, I would.

3832. That might be part of the reason that this particular device has been found?—I think it was historically part of the reason and not only is that true in relation to private practice, as it was before the existence of the Health Service but as Mr. Gunlake has said, even in the Universities themselves, to which I have referred. I think it is Lord Moran who has drawn attention to the fact that for quite a long time there have been instances where University teachers who were at the same time what I call specialist doctors were receiving special rates of remuneration out of line with those available to their colleagues in the

Universities. This is an issue, Mr. Chairman, which is, of course, a matter of the greatest importance to the Universities and I think that if the Commission were contemplating any recommendation which would involve a departure from the present limitations on eligibility which would affect the position of a certain number of people in the Universities I would venture to suggest that it would be a good thing to give the Vice-Chancellors' Committee or some appropriate representative body an opportunity of tendering evidence on this.

3833. We are hoping to hear the evidence of the Vice-Chancellors' Committee before so very long, Sir Thomas, and we have that in mind. But it is, above all, at the Universities that this matter becomes so extremely important.—It is.

3834. *Sir Hugh Watson*: Of course you have in mind, Sir Thomas, that Spens did recommend that the special committee should be prepared to recognise special contributions in medicine in the field of research or otherwise?—I have.

3835. But you would limit them to the clinical field?—As a practical matter I would advocate staying where we are in spite of what the Spens Committee might have thought on the subject. I think that the whole of the history of the last ten years has demonstrated how difficult an issue this is for the Universities and I think has demonstrated the desirability of remaining where we are.

Chairman: It is perhaps worth adding that the Spens Committee was only engaged in recommending the range of total professional remuneration of those engaged in consultant or professional practice in any publicly organised hospital and specialist service so they were not asked to deal with what research workers outside the hospital might be getting.

3836. *Professor Jewkes*: I think Sir Thomas made it quite clear that you could not apply the merit award system to general practitioners but I am still wondering whether there is any chance of making it possible to give something extra for age and experience among general practitioners. The kind of case I have in mind is this: at a certain age a general practitioner may have quite

a large list. He gets older, he may become a better doctor by reason of age and experience—not necessarily so, but he may very well become so—but is not able to deal with such a large list. Is there any way, through which, perhaps by some modification of the capitation system according to the age of the doctor, allowance could be made for that or is that hopeless?—*Sir John Hawton*: We would not be able to think at the moment of a way of doing it because we would question the premise that age and experience necessarily merit higher remuneration in general practice. I mean I quite agree that in some cases such as you describe it may be true but in others it will not. If you were to evolve a differential capitation basis on age and experience you would, in fact, be paying a lot of the wrong people as well as some of the right people, so we do not think it is really feasible.

3837. *Chairman*: Would you feel that the partnership system to some extent makes allowance for that if it is properly organised?—I think it does and we are very keen on partnerships.

3838. *Sir Hugh Watson*: Another suggestion which was made to us was that special treatment should be given to areas of exceptionally high morbidity. Would you think that was possible?—I should not have thought so. It would mean determining the rate of morbidity in each area. It would mean checking it from time to time because presumably it would keep altering and it would mean vast scheduling of areas. I do not really think it is practicable.

3839. *Chairman*: Just one more question on the merit awards. We gather that once you get an award you keep it for ever. You may, in fact, go on to the next one up but it is never reviewed downwards. That itself seems a somewhat unusual provision. Would you feel that, on the whole, that is best? Lord Moran said to us that he had taken on many difficult tasks in his life but he would not take on the one of deciding whether people had ceased to deserve an award, that would be too invidious, but he fully sympathised with the principle. Have you any comments?—I should have thought when you are dealing with merit awards you are dealing with an ascertained degree of distinction and ability. I cannot imagine that is going for some curious reason

to disappear or be diminished. If it is really there the man has achieved it, he has got it. It is rather different if you are dealing with payment attached to posts and the man goes to a more leisurely post, or anything of that sort. But this is really branding a man as having reached a certain degree of skill, and I cannot believe that a man reaches it and then loses it.

3840. I would not be quite so sure about that, because in fact this is a competitive system. There is only a certain proportion receiving awards, and you are really branding a man as being within the first body, 34 per cent, or whatever it may be. And there is the young man who may have reached that same level of skill and have deserved that same brand who cannot get it until someone who may be in some quite different social order dies. Is not that really the position? —I think that is a fair criticism of what I just said, a qualification of what I have been saying.

3841. It is not an absolute standard. —I should have thought what I said was subject to that one qualification. Then there is the practicability side. First of all it is difficult enough, as Lord Moran would say, to go round the whole of the country finding out which of the consultants are ones which should have awards, but if you then have periodically to go round and see which should now give them up, it would be really almost impossible.

3842. That was the suggestion. I agree about the practicability; it would be an extremely difficult thing. —I do think there is an element of truth in what he says, apart from your point, which, if I may say so, is a very good one in general. This is not a payment for doing a job. This is a payment for having achieved a certain degree of merit and skill, which one presumably retains.

3843. And it is a recognition that must never be seen because it is secret. —I told you I myself hold no very strong views on that.

3844. *Mr. Bonham-Carter*: Would you agree if in fact anybody did attempt to alter the system so they were reviewed annually, the result would be exactly precisely the same? —I have no idea. Fortunately I have never been charged with the task of ascertaining who has merit.

3845. *Sir David Hughes Parry*: There is some safeguard, is there not, in the fact that it goes up by three stages, C, B and A? There is some safeguard? —That is a safeguard, but it does not, of course, entirely dispose of the Chairman's point.

3846. *Chairman*: We have come across another problem rather acutely, and that is the question of recruitment of junior house officers and registrars in peripheral hospitals. That would seem to us to have become much more acute since the development of the service, because in the old days these men used to go to the teaching hospitals for nothing, except the opportunity of being taught and their keep in the early stages. Whereas if they went to the hospitals that were in some ways less attractive, particularly because they did not supply teaching, they were properly paid. Now there are the same conditions at each hospital, but perhaps more agreeable in the teaching hospitals; and it is a fact, is it not, that some of the peripheral hospitals are finding the greatest difficulty in getting registrars, and even in getting junior house officers from those people whom one would wish to see trained up to act within the service for the whole of their lives. The posts are very often filled by people who are going to go abroad, people who come here for training, who complete their training, and go abroad immediately afterwards? —Frankly, I do not know the answer to that. I do not know how far it is true. Whether there is information I can get for you I do not know, but the people who would know that, of course, would be the Regional Boards.

3847. I think it has been put to us pretty generally. —If I can get any information I will, but I am afraid here and now I do not know the extent of it, and how far it is so.

3848. It has been suggested to us in Scotland that one of the methods, rather than introducing differential payments with more money for going to the less attractive hospitals, is to appoint a junior house officer in particular, and perhaps even a registrar also, in such a way that he does serve at both kinds, or all kinds of hospital during his period; he should not be appointed to a particular hospital but to the Board. What sort of views have you on that? —I am afraid that is something I have not thought about

at all. I am disappointing in this answer this time, and I am afraid I have no views.

3849. You have not anything, Dame Enid, on this particular point?—*Dame Enid Russell-Smith*: No.

3850. It is rather an important question, because I would suppose the success of the hospital service as a whole must depend on having the peripheral hospitals staffed well, and not merely the teaching hospitals?—*Sir John Hawton*: Of course it does. I am wondering—I cannot help thinking how unhelpful I am being—I am wondering if we could, if the Secretary of the Commission would put the question or questions on which you want our view, get a considered view between us at the Ministry, and submit it to you on paper.

3851. I think we would like that, because it must be quite material.—How helpful I am being—I do not know, but it would at least remedy the defect that I cannot give you a view now.

3852. One suggestion on that—again you may not be able to give a view—is that an appointment as registrar in a non-teaching hospital might be a very normal preliminary to entering general practice. And that necessarily will depend partly on how easy it is to go from being a registrar into general practice.—*Dame Enid Russell-Smith*: That is I think the answer, that at the moment there is in most areas very great competition to get into general practice. There are two main ways in which people get into it. The most common way is to be accepted as an assistant, or as a partner by an existing group of practitioners, and something over 70 per cent. of all vacancies are filled in that way. The remainder are filled by advertisement and the selection of candidates from a list, first by the Executive Council, and then finally by the Medical Practices Committee. Those bodies naturally choose from the list before them the man they think most suitable for the particular post. There are often a large number, a very large number of extremely suitable candidates, so that it would in those circumstances be most difficult to make a particular qualification an overriding criterion.

3853. It might be possible, Dame Enid, to have such a salary structure that somebody did not have to suffer an enormous drop in income after doing a

year as registrar if he then became an assistant.—It would, of course, be so possible, but it does turn on whether that particular preparation really will produce the ideal man to go into general practice.

3854. I would like your views on that, because it has been put to us very much that the best general practitioner knows more about the hospital service than just having done twelve months as a junior house officer; and that it is also, though this is slightly different, a considerable advantage if more hospital doctors know a bit more about the general practitioner side.—Without in any way dissenting from that, the position is that, as I have tried to explain, it is not for the Ministry to decide who are the best doctors to go into general practice. That decision is taken in the vast number of cases by the members of the partnership which the new doctor will be joining. In a small number of cases it is taken by the Medical Practices Committee acting on the combined advice of the local medical committee and the Executive Council. There is no way in which the Ministry can influence the matter of choice as between the different practitioners who present themselves.

3855. There may be a way that we can influence it. It is I think becoming obvious that more registrars ought to be able to find an easy way into general practice rather than have to make up their mind to be in the hospital service for ever if they once become a registrar, is that right?—That view is put forward, yes.

3856. Is it a view held on the whole in the Ministry?—I think yes, subject to this qualification, that in the Ministry we do hold the view that entry into general practice by way of an assistantship is a very suitable and proper form of entry, because we do not think a hospital doctor is necessarily ready to be in full charge of a practice. Put it this way, we think it better that he should be under a certain amount of guidance and help for a year or two before he is in complete charge in general practice.

3857. Would you think that it would be even better if he was an assistant, perhaps for not quite such a long time, having been, perhaps, a registrar also in hospital?—We would hold no very strong views as to how long he should be an assistant.

3858. Mr. Anderson, or Mr. Graham, I do not know whether you may have something to add on this, but it was in Scotland this was put to us particularly strongly, that it was important to achieve something of this nature?—*Mr. Graham*: I do not think we have any view materially different from what Dame Enid has said, that there are two kinds of experience. There is the experience to be gained in hospital, particularly in the broad specialties. I think there are serious doubts about the value for general practice of experience in some of the narrow specialties, but it is very difficult for a layman to express an opinion on that, indeed impossible. Undoubtedly there is a feeling that experience in general practice as an assistant is almost essential.

3859. Mr. Graham, in Scotland are you finding difficulty in staffing the peripheral hospitals at the junior house officer and registrar level compared to the teaching hospitals? I know in Scotland you have a specially high number of teaching posts, have you not? It probably is not as acute, but are you finding much difficulty?—*Our impression* is that the difficulty is particularly evident at the registrar level.

3860. Have you any suggestions about what should be done about that for the peripheral hospitals?—*Our view* would be that it is bound up with the question of structure.

3861. Do you feel, for instance, this point that I was putting to Sir John, that it might be possible to appoint a registrar to a group, so that he serves part of his time in a non-teaching and part of his time in a teaching hospital, or would that at the registrar level be particularly difficult?—*At any level*, and I say this because some attempt was made to do this at the senior registrar level, you get into the practical difficulties of a man moving his residence, perhaps his family, at various stages in order to fit in with this curriculum that is laid down for him, and it is not in practice an easy thing to achieve.

3862. A registrar post at a teaching hospital at the same salary has obvious attractions over a registrar post further away?—*Yes*.

3863. For which there used to be a kind of compensation which no longer exists?—*That is so*.

3864. *Professor Jewkes*: Is it generally accepted that it is more difficult now for a registrar to move into general practice than it was before the Health Service was established?—*Dame Enid Russell-Smith*: I think that I should say on this, Sir, that there is great competition for vacancies in general practice; and there is a large list, a very large list of good candidates for all the more attractive vacancies. By reason of that competition it may well be more difficult.

3865. Are we not then getting in a special difficulty in this way? You recall that a little earlier I mentioned this extraordinary increase in the number of registrars, and the answer that was given was that this was perhaps due to the fact that the registrar grade was not merely a training grade, but increasingly was a staffing grade. So that in fact the proportion of registrars to hospital staff of a senior salaried nature is increasing. Unless there is some escape for those registrars, are you not going to have the problem of blocked registrars, just as you have it for senior registrars?—*Sir John Hawton*: It is essentially part of the thing you were on earlier. This is one part of the problem of the hospital structure which we do not think is right, which we cannot come here today and pretend to solve, which we are trying to discuss with the profession. But I agree it is one part of that problem. May I make one general comment, it is very general, on this business of the registrar becoming a general practitioner? In the Ministry, as Dame Enid said, we would regard it as quite improper for us as bureaucrats to have any say in the matter of who would or would not make the best general practitioner in any given case. We think that must rest with the partnership he tries to attach himself to, or if he is alone, with the Medical Practices Committee and all the attendant machinery. That is the first principle we work on. But I would agree that assuming that that means there should be for those people a free choice of whom they prefer as general practitioners, it may be a reason for not impeding that choice by the salary structure. That may therefore very well be a concern of ours, to make sure that the very freedom which we want, the freedom of choice, is not impeded.

3866. *Chairman*: It would seem to us that there is a freedom of choice which may have to be made at too early an age.

—And that may affect your recommendations. I quite agree, but I was pointing to two things, our side of it, and yours, as it were.

3867. You have deliberately, by using remuneration to encourage it, encouraged the growth of partnerships, for instance, in general practice, and you have deliberately by loading encouraged the medium size lists rather than the very big lists. There would seem to be therefore no particular objection to using remuneration to some extent as a means of encouraging more fluidity between the two sides of the profession, to what seemed in general desirable, or at any rate preventing the remuneration structure from being a complete bar. You would agree with that?—Anything which facilitates that interchange we would welcome.

3868. Thank you very much. It would seem to us to be quite important that that should take place, and you will be letting us have some more facts and figures about the difficulties?—About the difficulties in the peripheral hospitals. I am sorry I was not able to give you those now.

3869. The General Board of Control in Scotland—if we might come to that particular point—have given evidence in favour of additional remuneration for medical superintendents of mental and mental deficiency hospitals over and above what they would be entitled to as consultants. We would like to have the Department's views on that point, particularly bearing in mind this recently disclosed information in the House of Commons that on the whole people in this branch rank proportionately very low in the merit award list, and that on the whole they probably have no opportunities of part-time practice.—*Mr. Anderson*: This is really part of the discussion we have been having earlier about the system of merit awards, and whether it would be possible to allocate the funds in a different way according to responsibility. If that in fact had been possible, then this would have been one of the advantages that would have flowed from it. The superintendent of a mental hospital, undoubtedly does have considerable responsibilities for the health, safety and well-being of his patient, and that might well have been one of the ways in which the responsibility would have been recognised. But if we must accept, as I think we must, that respon-

sibility cannot be recognised in that fashion, I am not sure that we as a Department would have felt that the position of the physician superintendent of the mental hospital was such an outstanding case as to justify special treatment. There will, after all, throughout the service be consultants who in the nature of things are carrying greater responsibility than others. That is part of the price you pay for having a uniform grade, and it is part of the difficulties that you meet in trying to break away from it. One appreciates the point that the General Board of Control have made, and I think it is a real one, but I am not sure the way to meet it is to make a particular exception in this particular field.

3870. Can you suggest any way in which it could be met?—Unfortunately no, short of something quite fundamental, which I am afraid we are not prepared to contemplate.

3871. *Sir Hugh Watson*: The reason, as Mr. Anderson is aware, why this suggestion was made is because these gentlemen, in addition to having to do the duties of their rank as consultants, are responsible for the liberty, the safety, and so on, of the people under their charge, in some cases in quite large hospitals. I know the Board of Control feel quite strongly that the responsibility which these people have in their capacity as head of the hospital is considerably more than the normal responsibility of the average consultant. That is why they raised the point.—Yes, I appreciate the point, and I know it is a real one, but I should be surprised if there were not elsewhere individual consultants who were also in their own respective ways carrying responsibility above the average, and without any more access to distinction awards.

3872. Can you call to mind any comparable cases?—Not offhand, Sir, no. I was speculating I am afraid.

3873. *Chairman*: The position in England is slightly different I think?—*Sir John Hawton*: Yes, it is. We do not have quite the degree of the problem, but we should agree entirely with what Mr. Anderson said.

3874. I must pursue that a little further. It would seem that simply having the additional responsibility of administration and superintendence is not a par-

ticular reason for a merit award. It is not an outstanding contribution to medicine, but it really is a separate and definable additional responsibility, is it not, that usually from its very nature prevents them from taking on extra work outside?—I should have personally thought that the responsibilities of the kind described by Sir Hugh Watson of looking after liberty, and protecting the liberty of the subject and so on, are not the kind of things for which distinction awards were devised. I do not think the distinction awards have been thought of so far as relating to responsibility for, say, the proper and decent custody of people whose liberty is restricted, and I do not think it is that kind of basis we should have.

3875. That is exactly what I was saying, that this would not seem to be a case for distinction awards, but a question of whether it is a case for additional recognition in salary by virtue really of having two quite separate salary posts.—When you are dealing with whole-time posts, surely we must assume that whole-time posts are whole-time. Whether some part of the time is spent in one way or another, it simply means a man is doing two kinds of jobs; but the two put together are a whole-time job, and that is the same with the whole-time specialist.

3876. That takes us back to another point. We know that on a sessional basis part-time consultants can have anything up to nine-elevenths, or nine defined sessions of 3½ hours each. Do you feel the whole-time consultant has really eleven-elevenths, eleven sessions, or that he does more than eleven-elevenths?—*Sir Thomas Padmore*: More than one hundred per cent. full time?

3877. More than so many hours per week.—*Sir John Hawton*: We have always assumed full-time to mean for convenience eleven-elevenths, but we mean, of course, a continuing responsibility, on the job all the time.

3878. It is based upon the five and a half day week?—It is based on that, yes.

3879. And in fact it may be the medical superintendents by virtue of this additional responsibility have rather more time involved than others, I do not know.—It may well be a whole-time specialist by virtue of his continuing responsibilities to his patients may have

to do in fact more than eleven-elevenths, indeed he may.—*Sir Thomas Padmore*: This is the sort of problem that arises all over the public services. Wherever you have a hierarchical system with grades and fixed rates of pay you have to cover by one grade and one rate of pay a pretty wide variety of functions and jobs, and even jobs which are not strictly comparable, or indeed which nobody would contend are exactly on the same level of responsibility or skill required, or anything else. For instance, if you look at the Armed Forces, you will not find that all the generals, although they are paid the same rate of pay at all times have the same kind of responsibility and the same kind of function: the same is true in the Civil Service. And it is bound to be true in this service too. It may be a question whether having regard to the difference between the particular people in these mental hospitals with whom we are concerned, the difference between them and other consultants, whether the difference is so big that it is not reasonable to sweep it in in what we call a broad band. As to the merits of this particular case I have no views—I am not informed about them—but it certainly is the case, and one would expect to find, that these differences in types, and indeed in importance of job, provided they were not too extreme to be swallowed, would arise all over any kind of graded service of this sort. Therefore I suggest the only question is whether this is a particular instance that is so extreme that it is not reasonable to leave it, whether it is so extreme that some special arrangement ought to be made.

3880. Exactly.—I should not be in the least surprised to find that if you made a special arrangement here you will have with you another claim.

3881. *Sir Hugh Watson*: There is, as *Sir Thomas* is aware, an arrangement for paying schoolmasters at a certain level; certain salaries are weighted by responsibility because they are heads of departments, and things of that sort. That is not altogether dissimilar to this case.—No, it is not.

3882. *Chairman*: There is also, since *Sir Hugh* mentions that, the fact that local education authorities, recognising the quality of all types of schoolmasters, have something at their disposal so as to give a bit extra to people who may happen to be science teachers. They

may not, but usually do so at their discretion, is not that so?—I believe so, yes.

Sir Hugh Watson: I am told that does not apply in Scotland in the same way, and as *Sir Thomas* has not to bear that burden in Scotland he can bear this one instead.

Chairman: I think we shall be able to finish the remaining points this afternoon.

(The proceedings were adjourned for lunch)

On Resumption.

3883. *Chairman*: There are only one or two questions arising out of what we were talking about before, just to finish that particular example. We did happen to mention the local education authorities having a sum of money that they can distribute to meritorious people in the teaching profession over and above the Burnham scale which may go to anybody. That has relation both to comparable professions and to comparable attractions, as it were, and that would seem to be a precedent for letting local bodies of one kind or another have some discretion in rewarding meritorious people in their service. Admitted that those are salaried people, which general practitioners are not, but there is some kind of a precedent for that.—*Sir John Hawton*: I do not know, of course, what the local education authority position is, I mean except what we heard this morning, but I should have thought that there was a very big difference between a local authority directly employing salaried employees, and a body which is simply in practice distributing a pool of Exchequer money to doctors, and which has no jurisdiction, broadly speaking, over them in the sense of employer relationship. It is a contract for service rather than of service.

3884. It would be a considerable extension of the principle.—I should think if you began to contemplate it—I am only thinking aloud, because we had not thought of this—you would have to go right into the field of altering the constitution of the authority which had that discretion, or else invent some new, perhaps, advisory or other machine in every one of the areas to do it. I cannot imagine the present system catering for that kind of thing.

3885. No. I mentioned it because *Dame Enid* said earlier that nobody has yet been able to think of a good system of rewarding merit among general practitioners other than the present system of counting heads.—No.

3886. And we may have to do something pretty novel if we are to get a real family doctor?—My first reaction to that would be that it would be very complicated indeed in the case of the present general practitioner service, and also might, unless one was very careful, produce all kinds of local anomalies which would create the opposite of the kind of trust which you mentioned we want to establish.—*Sir Thomas Padmore*: I would have thought, too, Mr. Chairman, that the case of the teachers which you have mentioned is not, perhaps, as close an analogy as all that, because, if I remember rightly, the special payments made to schoolmasters are responsibility allowances, and not attached to anything as intangible as distinction or merit. I should think it much easier to run a system of that kind where it is attached to special responsibility, and therefore in a sense attached to the post.

3887. But it was an innovation which at the time was a quite revolutionary advance, and it may be some other revolutionary advance will have to be invented by somebody to deal with this particular problem.—It may be, but it would be rather a different kind of revolutionary advance from the one in the teaching profession.—*Sir John Hawton*: And it would have to be in the nature of things administered by, I use the word loosely, somebody in a position to know and judge the quality of every general practitioner's work. An employing authority employing schoolmasters is in a much easier position to know which are its good schoolmasters. Certainly the present Executive Councils and others have no real knowledge of the nature or the quality of the general practitioner's work—it is not their job.

3888. All those difficulties are certainly there. Just one other question on the same point. Would the Departments feel that the ceiling of remuneration at which a whole-time consultant can aim should be very much superior to the ceiling of remuneration that a single-handed general practitioner should be able to aim at?—This is the question.

really we had, was it not, yesterday about the differential?

3889. Not quite.—The relativity between the two.

3890. Not quite. You have relativity in averages. I was thinking in terms of the exceptional man in the two branches of the Service, because I do not think it has ever been challenged that there are exceptional men in general practice as there are, although there may be more, exceptional men who specialise.—One does not challenge the principle, of course, that there are exceptional men in both branches, but I should have thought myself that if you have the relativity in the averages—if you think on the whole there should be a higher average for the consultant—then I should have thought that also carries with it the assumption that the top level should be a higher one for the consultant than the general practitioner.

3891. It should be higher, but perhaps in the same sort of relationship.—As the average?

3892. Yes, although not necessarily.—That would seem the sort of approach, yes, I should have thought.

3893. The difference is that in the hospital service you have precise machinery, when it works, for getting the best people the best remuneration, and it would seem rather doubtful that you have quite that machinery in general practice.—I accept that, I do not think you have. Neither machinery is sure, but I do not think you have so good a machinery in general practice.

3894. Now we will leave that, and we will turn to the next paragraph that I wanted to ask about. We again would seem to have covered this, but I would like your views on it. The Spens general practitioner recommendations really did lay a great deal of stress on the spread of incomes; they really laid more stress on that than anything else, and they went into a great deal of trouble over it. And the only attempt at implementing that seems to have been to apply an equivalent average income without regard to the spread. It seems as if the attempt to produce a spread anything approaching the kind of spread that Spens recommended was not made to begin with. A spread has been produced but not as a deliberate attempt to implement the Spens spread?—*Dame*

Enid Russell-Smith: Yes, Sir, it is broadly speaking so, the ground being that we found that the capitation system, which is the backbone, but not the whole of general practitioners' remuneration, was incompatible with a controlled spread, but we did do certain things to try to widen the spread that you would get on a pure capitation system. The special payments for maternity medical services which were mentioned this morning was one; the grants for the training of the assistants was another; the mileage payments in rural practices were yet another. All those are modifications of the strict capitation system which aimed at somewhat increasing the possibilities of a spread. There is, also, of course, the inducement payment in areas which are specially unattractive.

3895. I am sorry, but do not the inducement payments in unattractive areas, and the mileage payments in fact reduce the possibility of spread by evening up rather than widening?—I think the inducement payments do, but not mileage payments, which in some rural areas may be very considerable.

3896. And they produce the greater spread and not a smaller?—I would say that they increase the weighting at the upper end in those areas.

3897. None of this was done that there should be regard to Spens, although you have accepted Spens in principle?—Not with direct reference to Spens, though I do remember a conversation with Sir Will Spens at the time, in which he welcomed the maternity medical services payments as a possible means of improving the spread over a capitation system.

3898. On the whole it is still true to say that really you have not actually aimed at the Spens distribution?—No, we have not, for the overriding reason that with the profession's full agreement we wanted the capitation system of payment. We wanted to preserve the capitation system as the major channel of remuneration, and that was not, so far as our experience went, compatible with a controlled spread.

3899. Is the result then that you have landed yourselves with a lot of doctors who are very dissatisfied because they get much less than they would have got otherwise, and a lot of doctors who say

nothing but are very satisfied because they have a great deal more than they would have got otherwise, or is that an exaggeration?—While, of course, everybody knows that there is this irreconcilable difference between the Department and the profession on the question of remuneration, I hope that it is not true that a lot of doctors are dissatisfied generally.

3900. It might still also be true that a lot of doctors are getting a great deal more than they would have done on the kind of basis on which Spens worked.—I think that is possibly true, but we shall be producing figures for you later from which you will be able to draw certain deductions regarding the spread.

3901. We will not necessarily be able to draw deductions as to whether the doctors who now come out better are the doctors who would have come out top if it had been a different system.—No, no one can say how the Spens formula, if it had been possible to apply it, would have fitted with the pattern we have now.

3902. Just one other question on that. You adopted for the external private earnings one figure which has remained unchanged since (Danckwerts—£2 millions, is it not?—Yes, private practice.

3903. Why have you left that unchanged, and, as it were, unchallenged ever since?—We have left it unchanged because we have not been able to obtain so far any accurate information as to the extent of private earnings. We are engaged in trying to get better information on that point.

3904. You have no information at present?—We have no better information at the present moment.

3905. Do you believe that the actual figure remotely resembles the figures you have taken?—I do not think we are in a position to say.—*Sir Thomas Padmore*: We have been exploring the possibility of getting some better information on this subject. We supposed that the Commission would refer to the fact that this is an extremely old figure, a figure about which as *Dame Enid* has said, we have no idea as to its accuracy, or indeed as to whether the true figure is anything of the same order or not. We have been exploring with the Inland Revenue the possibility that they might be able to furnish the Commission with

some better figure. The difficulty we have come up against is that there are a great many practical reasons why the Inland Revenue find themselves unable to do a comprehensive study of the professional earnings of general practitioners apart from what they earn under the capitation system. But it looks as though, if the Commission were to think fit to ask the Inland Revenue to do so, they might well be able, with the collaboration of the health authorities, to do a sample study of sufficient size to justify the drawing of fair conclusions as to what the total figure is. The difficulty about that is that, as I understand it, so far the representatives of the professions have been entirely unwilling to contemplate any use of Inland Revenue figures based on a sample rather than on a comprehensive study.

3906. I think there is a difference between the two professions. I think the dentists have been much more willing than the doctors.—It may be. I am not very well informed about the dental aspect of the thing. It was the £2 millions in particular about the general medical practitioners I was thinking of, and it seemed to us that if the Royal Commission would like to pursue the possibility of some useful information on these lines being got from the Inland Revenue, they might think it right to see whether they could not secure at any rate some acquiescence from the representatives of the profession in a study of that kind being made. I think that the Revenue would find it difficult to undertake a study and to make their figures available if they were doing it, as it were, in the teeth of declared opposition from the profession. But if the profession would be willing at any rate to acquiesce in such a procedure, I should have thought that it might well be possible for the Secretaries to consult with the Revenue and get them to undertake something that would be useful.

3907. Thank you very much. We will, of course, get a lot of figures from our own enquiry into earnings, at least we think so. But we might still wish to pursue that suggestion because the present position is rather like that of depreciation of plant, in that the figure that is used is known to be miles out, but for some reason it is better to use one that is known to be extremely wrong than guessing upon something that may be much less wrong.—Except that this one is not even known to be miles out.

3908. The depreciation one you do know is miles out! We will leave that one. Depreciation in general is not strictly within our terms of reference!—I recognise that.

3909. In paragraph 119 you describe how you have from time to time in the Government adopted various measures to introduce some new habit, for instance the financial inducements to encourage partnerships and to encourage group practice. Do you consider that that is becoming so much an established thing now that financial inducement itself will no longer be necessary?—*Dame Enid Russell-Smith*: No, Sir. We do take the line that we would like to see a continuance of partnerships, and a continuance of an increase in partnerships as in the past. We think there is still a field for it, and we say here we see no objection to remuneration continuing to influence the increase of partnerships as heretofore. I think we may say we wish the partnerships to continue to increase, and I do not think we could be sure that that would be so if the inducement was stopped.

3910. Partnerships have advantages for the practitioners as well as for the patients, have they not?—Yes, so we understand.

3911. In rationing the amount of night work, and off duty time, for example, as well as in consultation between two people about the patients?—Yes, we are advised that it has very great advantages in consultation, and the encouragement of minor specialties, and in improving and increasing the level of professional skill as well as the more mechanical advantages of giving the doctor a rather better life.

3912. And these partnerships are given financial inducements largely by the transfer of more of the central pool to partnerships?—That is so.

3913. Which means that it is at the expense both of those who could go into partnership but choose not to in some areas and I suppose in some other places of those who, by the geographical nature of their position, probably could not easily form a partnership, is that right?—On the present basis on which practitioners' remuneration is calculated, every special payment is, of course, in some way at the expense of other payments.

3914. But you feel happy that the extent of this special payment is not sufficient to be an unwarrantable hardship on any of those who cannot go or do not go into partnership?—This was fully agreed with the profession, and they have never suggested to us that it was open to that objection.

3915. I was asking your view, and not the profession's.—We have no evidence whatever that suggests that.

3916. You think on the other hand that the inducements are ample or enough now?—I think so, because you will have seen from the figures we have given you that partnerships are increasing at a very satisfactory rate.

3917. That is what made me wonder whether the time was coming when the inducement might be perhaps a bit less necessary, because you will expect to start with an inducement to get a good habit formed, but you will not need it as much afterwards.—Except this, that you see it is a fresh practitioner in each case going into a partnership. The individual has not formed the habit.

3918. No. Have you any idea at all of by how much expenses are reduced in partnerships?—No, I am afraid we have no information on that.

3919. Because presumably that is another financial inducement in many cases which is in every way in the community's interest.—Yes. I think it would vary enormously with the type of partnership, and the type of area in which doctors practised. Of course you get partnerships in which it is difficult to see that there could be very much reduction of expenses at all, although you would still have the advantage of consultation, of the doctor not being alone, and all that. On the other hand when you get to the type of partnership that turns into a group practice you might have a considerable pooling of expenses, but you would also get we hope a higher level of facilities which might cancel that out.

3920. The Commission understands the difference between partnership and group practice, and you say that the development of partnerships has been satisfactory. Does the same apply to group practices?—Yes. Within the total money set aside for it we have for a considerable time had more applications than we could deal with. That position will rectify it.

self in time, because the money is advanced, as you will be aware, on interest-free loans, so much each year, and therefore the fund is cumulative.

3921. Yes. On the whole you want to see the trend to group practice proceed more quickly?—We want to see it proceed as quickly as it can in relation to the money now available, and we would welcome an even quicker increase.

3922. Is the money available for that purpose taken from the central pool?—Yes, it is set aside every year.

3923. Have you considered taking more if you want more group practices?—No, we have not, because it is an increasing fund. It is £100,000 every year, and as the loans are paid back it increases, so in time it will clearly become excessive. It is merely a question of spreading out the money over the time.

3924. You do not want to pay it out more quickly to exhaust the need so that you can start as it were distributing more to everybody from the central pool?—There is another factor coming in. It involves capital outlay, and we would not want suddenly greatly to increase the amount of building done at any one time that would not fit in with the general plan of capital outlay.

3925. It is not a very great sum.—No, it is not, of course.

3926. Going back to a previous point we in fact have figures for six years ago that show that the expenses for a sample over a fairly small period were quite noticeably less in partnerships than in single-handed practices. That is what I would have expected.—Yes. You are referring to the figures we provided you with?

3927. Yes.—Yes, I am sorry, I had overlooked that.

3928. It came from the Inland Revenue in January, 1954.—Yes.

3929. So apart from anything you may do in the way of transferring money from one set of people drawing from the central pool to another, there is this considerable financial inducement that is a direct saving to the community. You are prepared to pay the extra amount by this internal transfer to speed up this process of forming group practices?—Yes, bearing in mind, Sir, that at the outset of the Service a great deal was being thought and investigated about the

organisation of a general practitioner service. The British Medical Association among others had committees which reported on the subject, and it was the professional isolation of general practice which was said to be one of the great obstacles. That was I think the reason why the conception of the health centre caught on so quickly at the time even before the implications of it had been worked out.

3930. You feel everything points in the same direction, the advantage to the practitioner, the advantage to the public, and the advantage to the Service as a whole?—We do indeed.

3931. Now can we turn to Section 13—this question of assistants, which is rather separate from the rest of the doctors, although perhaps a bit more parallel with the dentists. You say quite firmly that the relationship is a personal one between the principals and their assistants, and that you would not wish to intervene in that. None the less there are some safeguards that you say exist already to prevent exploitation of the assistant. It was a very definite recommendation again of Spens, was it not, that the assistant should be assured of a certain minimum, which in terms of betterment would now be £1,000 a year? Do the Ministry feel any responsibility at all to see that that is carried out?—The Ministry have, except in the case of the trainee assistants where the Ministry have accepted certain general responsibilities, consistently regarded the conditions of service of the normal assistant as a matter between him and his principal.

3932. Are you satisfied that if necessary assistants should go on in assistant posts one after the other without much security of tenure and constantly applying for assistantships?—We have not thought that was a matter in which we ought to intervene. We do think the best form of entry into general practice is by way of assistantships. We therefore certainly would not want to detract from the repute of an assistantship, and we cannot help feeling some of the criticism of the system is perhaps exaggerated. We also know that there is a small number of people who, for one reason or another, either do not wish, or frankly are not fitted, to work as principals. It is only a small number, but the total number of assistants is not large.

3933. You will know perhaps that we have had a good many letters from assistants complaining of exploitation in one form or another. Does that surprise you?—Not very much, partly because we know that the unestablished practitioners are a very active body; they are well organised, and they react quickly and very thoroughly on behalf of their members.

3934. I was referring much more to individual letters that we have received, and not connected with any particular body.—I am a little surprised that you should have received a very large number of individual letters.

3935. You do not think that it would be advisable to have a standard agreement, that would really be almost a condition before you pay?—I think that we would welcome any voluntary steps which might be taken within the profession to provide further safeguards for assistants, but we would hope that it would not be necessary to write them into statutory regulations.

3936. I did not really mean them as statutory, but as a form of standard regulation, and with the B.M.A. perhaps taking the responsibility of vetting all assistant posts, something like that?—You see, if you do not make it a statutory regulation how would you enforce it?

3937. I am looking at your paragraph 125. You say:—

"The most satisfactory arrangement might be an agreement within the profession to observe certain conditions of employment of assistants which would avoid the necessity for writing them into the regulations. . . ."

You are suggesting an agreement within the profession that is enforceable by the profession, is that it?—I am suggesting a voluntary agreement which doctors would generally agree to observe.

3938. An agreement to agree?—Yes.

Chairman: I believe an agreement to agree is not considered by lawyers very effective.

3939. *Sir David Hughes Parry:* I wonder whether it might be possible to have standard terms of agreement? It might be possible to have a set of standard terms and get all those known among the profession.—I am sure that the professional associations could do it, but we would think it was a matter

better for them than for a Government department.

3940. *Chairman:* The other thing, Dame Edd, is that we have heard, of course, that when a doctor first takes on an assistant he is probably at a loss financially for a time because he is unlikely to increase his list, immediately at any rate, by the full amount to compensate for the salary of £1,000 or so that he will be paying his assistant. You do not feel that there is any need for encouragement in that way? We want to ensure that the assistant starts off at a reasonable salary.—I think that a lot of my observations spring from a very great reluctance to accept on behalf of the Department responsibility for policing agreements arrived at between the assistants and their principals.

3941. That was not my point. The point really was whether the payment to the principal in respect of the extra patients the assistant may bring into the practice should be sufficiently high to make it possible for the principals to pay whatever salary may be thought to be appropriate. We have been told that very often indeed they are at a considerable financial loss in the first year or so?—I do not think we would wish to object to a proposal that doctors with an assistant should be paid extra, but it would seem to have the corollary that you would then have to ensure that the extra money was passed on to the assistant, and you then do get into this rather intimate policing arrangement which one would be rather reluctant to embark on.

3942. In fact do not local Executive Councils already know the name of every doctor who has an assistant for more than three months?—They do indeed.

3943. Do they not have some responsibility for a certain degree of supervision over what happens?—They have no responsibility at all over the terms of the assistant's employment.

3944. No.—And it is that that I would be reluctant to accept on behalf of any Department or any local body which was part of the machinery of the scheme. It is such an intimate matter. The arrangements are bound to vary so greatly according to the assistant's capacity, according to the way in which he is employed. A lot of assistants are part-time, a lot of them are married

women, a small proportion of them are really unfit for other forms of work, people who have been overtaken by illness or misfortune of various kinds, and it would be entering into questions which really do not seem to me to be suitable for a public body to adjudicate on.

3945. In paragraph 127 you talk about general dental assistants, and you say that it is not surprising to find that various forms of inducement are being offered to practitioners willing to serve as assistants, that these have been taking the form of a bonus or payment of commission on work done, and that that puts an undesirable premium on speed. Does not the item of service basis as applied to dentists do exactly the same thing?—Yes, it does, but the type of agreement we have got in mind here is something which, feeling that that inducement to secure speed is insufficient, adds to it.

3946. I have not quite followed.—I am so sorry. You say the item of service system already is an inducement for speed. The type of agreement with the assistants we have got in mind here is intended to reinforce that inducement, and to achieve even greater speed.

3947. "Even greater"? Could you give a rather more concrete example?—We have in mind this sort of thing, that an assistant might be paid so much for the patients he treats up to a certain level, and then he paid extra for the extra number.

3948. You mean he might be paid insufficient for a real normal assistant's salary, unless he did more than the basic number?—No. I think that assistants in dentistry have a shortage value, which means that they are very well paid as a whole, but I had in mind a system so designed to increase their earnings, and to induce them to achieve greater speeds than they should.

3949. I suppose the basis is really the same with doctors as with dentists, is it not, that no doctor and no dentist is compelled to take on an assistant unless he wants to? He will not do so unless either in terms of more leisure, more satisfaction or more money he can see that it is worth while?—The big difference between the two professions is this. I think that there is broadly speaking no shortage of medical assistants. There is an acute shortage of dental assistants.

3950. As with doctors and dentists who are not assistants. And if one applies the law of supply and demand at all that would be reflected in the earnings both of dentists and of their assistants in comparison with doctors, is not that so?—That is so.

3951. And that is something that the Ministry, or the Government as a whole can do something to relieve by quickly making sure that there are enough places in dental schools.—That is what we are endeavouring to do.

3952. You have not quite got there yet?—No, we have not.

3953. Can we go on to Section 15. In Section 15 you give us in paragraph 130 the different average sizes of list per practitioner according to whether they have assistants, are in partnerships, and so forth. That table would seem on the face of it to show that the single-handed practice with assistant is in fact rather profitable, is that right?—Yes, I think it is.

3954. That is to say that he has, for instance, 1,400 or so more patients than either the completely single-handed man or a partner in a partnership of two?—Yes. Of course, again, Sir, there is a good deal of self-selection among these figures.

3955. Self-selection?—Yes. The single-handed man with an assistant will belong probably to one of two types of people. Mostly I think it is fair to assume that he will represent the man with the growing practice in search of a partner, and therefore one would expect his list to be large. There will be a small number of people, perhaps, whose health is breaking down, and who are selecting an assistant with a view to succession. Among the single-handed people without assistants there will be a considerable number who for various reasons are hardly in whole-time practice.

3956. Yes, I see that, but with a partnership of two they are probably normally both in whole-time practice?—Yes, but you see the man and an assistant have 3,600 between them; the partnership of two will have 4,500 between them.

3957. I realise that, but the man with an assistant is paying his assistant probably about £1,000 a year.—That is a figure that has been recently deduced from averages, yes.

3958. And on the 1,350 patients he will be receiving gross on the average . . . —On the 3,500.

3959. On the difference between 3,600 and 2,250.—But the loading comes in, does it not—I could not do the sum in my head.

3960. No, but it will be quite a lot more than £1,000, obviously.—Yes, though the partnerships will have two sets of loadings.

3961. We have worked that out; I do not think we need spend time on that.

I just want to refer to this question of chairside hours, because we have never quite got to the bottom of how it was that what happened in 1948 was so far from what had been anticipated. You say you think the Penman Report shows that, excluding the three groups of dentists with the lowest time who were presumed not to be in whole-time practice and the two groups with the highest time who seemed to be working themselves to death, the average was 37½ hours. You go on to say:—

“The information in possession of the Department is insufficient to enable a view to be expressed as to the number of chairside hours which can reasonably be expected of the average dentist at different ages.”

That is rather a fundamental figure. Does that mean you do not really believe the Penman Report figures are representative, or is it simply a question of ages that you are referring to?—It is principally ages; it is also the question whether the Penman Report which was based on an investigation in the first half of 1949 is representative of what dentists are doing now.

3962. It is of some importance, is it not, to know what are the normal chairside hours of dentists in what is for them full employment at these different ages, in view of the feeling that there is a very marked and rapid decline in the ability to go on working at full pitch?—It is information we should much like to have, but I am a little doubtful, Sir, whether it is possible to go into the refinement of age groups—the linking of chairside hours with age groups. It would mean a most detailed investigation and one which would be liable to be falsified very quickly.

3963. I hope that we shall get something about this in our own questionnaire to dentists which is coming in fairly well, but you have not any information on that subject?—We have no later information than the Penman investigation.

3964. And the Penman investigation showed an increase of about 10 per cent. or so in the hours actually worked compared with what Spens had suggested?—Yes.

3965. But the earnings showed a great deal more than you had expected under the items of service payments?—Yes. There were three factors in settling that first scale of fees which were proved by after events to be wrong. The first was the hours per week; the second was the dental timings, the timings of the individual operations. Both of those were put into perspective by the Penman Report. The third was the amount of the practice expenses on the volume of work being done. All those things together did produce results which neither we nor, I am sure, the profession had ever anticipated.

3966. I do not think I have anything I want to ask on the emigration and immigration figures. Those seem satisfactorily to explode some of the wilder rumours that were going about at times that everybody was dashing away from the country. You feel there is no significant thing there, is that right?—*Sir John Hawton*: That is so.

3967. *Chairman*: Now I would like to go on to the answer to question No. (18). I take it, Sir Thomas, that you do not feel that there is any one profession that is by itself so comparable with any one other that there could be a permanent tie—in particular one profession comparable with the medical profession—but more a group of professions?—*Sir Thomas Padmore*: I wonder in that connection if I might say a general thing which arises to some extent out of what you were saying yesterday. On this doctrine of fair comparisons the suggestion is implicit in your terms of reference that medical remuneration ought to have regard to comparisons with other occupations. I think there may have been some tendency in the past to think that at any rate in the case of general practitioners the natural comparison, and perhaps the only important comparison, was that with other professions in what I might call the fee-paid sector, the architect,

accountant, lawyer, in practice. I would like to submit that that is by no means the only valid comparison, and indeed perhaps not even the principal comparison. I think that attention has been directed towards these parts of the professions because their remuneration takes the form of fees and because they are members in the main of a learned profession generally thought of as being closely comparable in some respects with the medical profession. But in fact of course the remuneration of general practitioners, although it is not a salary, is the remuneration of a man who is either a whole-time—or fairly nearly a whole-time—servant of the public, and it is incidentally remuneration which carries with it pension rights. It is therefore I think at least as closely analogous with a salary, although it is not a salary, as it is with the fees that (say) a private practice lawyer earns. After all, although it is not a salary, it is not at all closely analogous with fees in private professions in that it is not computed as they almost invariably are by reference to particular services rendered, the scope of the services in a particular case; it is computed by a special arrangement which is unique for all sorts of reasons, among them the fact that that is the kind of system of remuneration that the profession wanted. But I do not think that the accident that the remuneration is calculated in that special way ought to blind us to the fact that there is, as I would suggest, a perfectly valid comparison between remuneration of the general practitioner and remuneration received by way of salary by other professions whether they be engaged in public service or whether they be salaried officers in the private sector. We would therefore hold—and I think this is part at any rate in answer to the question you have just put to me—that of course there are differences when one makes all these comparisons, but the objective ought to be I think to make as wide a comparison as is reasonably valid rather than to restrict and narrow things.

Chairman: You will know that we have been obtaining information about a number of people primarily in salaried employment as well as others. For instance, far more of the engineering profession than of the legal profession are in salaried employment in one form or another. We have not been restricting

ourselves in any way just to one or the other. And of course the hospital service is broadly a salaried service anyway.

3968. *Mr. Gunlake:* Of course, Sir Thomas, if there were in fact no appreciable difference between levels of remuneration produced by way of fees—thinking of my own profession for example—and those produced by way of salaries, it would make no difference anyway. Have you any reason to believe there is any difference in any main profession between that branch which is fee earning and that branch which is salaried?—None at all.

3969. Does the one not influence the other?—I would be rather surprised if there were any wide general differences, and indeed that in itself might be an additional reason for at any rate taking advantage of the relative ease of discovering what are rates of remuneration in salaried posts whether in the public service or outside it, compared with the relative difficulty of getting reliable information about fee-paid professional men.

3970. *Chairman:* Would you think it likely that on the whole there would be a wider range in any one occupation among the fee earners or self-employed than among the salary earners where on the whole there is more uniformity over a long period?—I should certainly expect that there would. It is obvious if you look at the Bar that the prizes of success are much greater in some branches of the private fee-paid professions than any that are available to salary earners anywhere.

3971. And, by contrast, earnings at the bottom end are very low?—Yes, the reverse is also true.

3972. Actually it would appear that in the medical profession the broadly salary earning branch of it, that is to say the hospital service, is rather higher paid than the fee earning capitation branch. And perhaps they have a wider spread too—I am not sure about that.—I do not know.

3973. *Mr. Gunlake:* This is rather an important point, Sir Thomas, is it not, because it is contended on behalf of doctors and dentists that, whereas in the old days the top flight surgeon, dental surgeon or physician with a Harley Street practice could rise to very considerable remuneration levels, they can no longer

do so and they have therefore ceased in that sense to be comparable with the fee earning professions. Do you agree that has been the effect of the Health Service?—It is true; it is of course a universal feature of all public services.

3974. *Chairman*: When you say "universal" you mean universal and not just this country, do you?—I would have thought so, yes. Certainly it is true in all other countries with which I have any acquaintance in this respect.

3975. *Mr. Gunlake*: Of course the salaried person has a certain security of tenure and other advantages which might be held to compensate?—Yes, and of course he is not so likely to starve in his earlier years, as the Chairman was saying.

3976. *Chairman*: I think we have it quite clearly that the Government accept the principle of fair comparison rather on the lines of Priestley?—They certainly have accepted the recommendations of the Priestley Commission in relation to the Civil Service. I see no reason why they should hold a different view if, for instance, this Royal Commission were to make recommendations of a similar character.

3977. In fact you put it as your view in one of the earlier papers that that is the principle you think should be accepted, and that you do not expect this particular profession to be used for either holding back or pushing up anybody else?—When we apply it to the Civil Service we put it in very simple terms like this: that there is no reason either why the Civil Service should be a privileged class in relation to remuneration or why it should be a depressed class. And I would have thought the same simple doctrine might well apply to members of other public services.

3978. *Mr. Gunlake*: You do say in paragraph 158 section (e) that one of the advantages of the Priestley Commission's recommendations was that the Civil Service should not lead in these matters but should tend rather to follow what happens outside. How could that be applied to doctors and dentists if the comparison is with other professional men including fee earning persons? How are the figures to be got at? Or do you contend that only the salary earning sectors of the other professions should be taken into account for the purpose of a comparison with doctors and dentists?

—No, I would not contend that. I would contend that any relevant comparisons about which information can be obtained should be made. Admittedly it is, as I have already said, more difficult to get adequate, comprehensive and reliable information about the fee-paid sector in the professions, but it is not by any means hopeless; one can get some information, and indeed a certain amount of information has been obtained in the past, and I should hope that information of that kind would continue to be available in the future.

3979. *Chairman*: I think we have had it from Sir John earlier, and I think you agreed that, apart from the relativity between the medical profession and other professions, what was of great importance was the relativity within the profession between the different branches, is not that so? So if that is at any one time established it is presumably possible to establish relativity with outside professions as regards the salary earners as easily as on any other section of it?—Yes. Obviously in the case of this profession, the medical profession particularly, what we would call in our jargon the internal relativities are very important to the health and indeed the morale of the profession.

Chairman: I do not think I have anything more on section (18). Then in section (19) you give us a very full account of the repercussions that would follow from any startling move in this particular field. Mr. Gunlake, I think you have a point on this you want to raise?

3980. *Mr. Gunlake*: I would like to go a little further, if I may, into paragraph 193. It is here stated, and I dare say many would accept the idea, that it can be an economically dangerous thing if too many people are automatically insulated against inflation. What did surprise me a little is that, in addition to this contention, there is set out in this paragraph the further idea that it is particularly undesirable that any such protection should be afforded to occupations in which remuneration is above the average of the community as a whole. I am wondering just where that leads us. Is it not the case that if inflation happens, as it has happened and perhaps will go on happening for a time, many of those people in the lower remuneration brackets are auto-

matically compensated by wage agreements, and others will be compensated quite rapidly by appropriate action in the industrial field; whereas the people at the top end of the scale are left out in the cold altogether. It seems to be contended here that that is Treasury policy—that is usually known as levelling down, is it not? Have I misunderstood this paragraph?—Where do we say this, Mr. Gunlake?

3981. *Chairman*: It is the last sentence of paragraph 193.—I do not think we meant more than this—it perhaps is not terribly well expressed—certainly we do not mean to say that it was in any sense Government policy that when remuneration was improved at the lower levels in response to changes in the value of money those improvements should stop at a certain level; indeed I think recent history in relation to the public services of all kinds has shown that that was not the Government's policy in this matter. I do not think we meant more here—it may not be terribly well expressed—than to say that there is less justification on hardship grounds for a link to the cost of living in the case of people on the higher levels of remuneration than there is in the case of people who are nearer to subsistence standard. I think that is all we had in mind.

3982. *Mr. Gunlake*: I imagine—perhaps you will tell me if I am wrong—your idea would be that if those sections of the community in the higher remuneration brackets do have revisions, those revisions should take place not every three months but every so many years?—Certainly.

3983. Which means they tend to be a little behind most of the time?—Yes.

3984. But there is of course a difficulty there to which I drew your attention yesterday. If, as in the case of the doctors, the Government intervenes at a particular point of time and says that owing to difficulties at this moment nothing can be done, and it happens to be a group of people for whom there has been no change for five, six or seven years, do you not think that the inference that would be drawn by those of us in other professions is that it is desirable not to leave these matters for a very long period in times of inflation; that it is as well not to wait five, six or seven years before adjusting one's level of fees and

so forth?—I think it may be; certainly it is not desirable to leave proper adjustments unmade for a long period out of sheer inertia or neglect.

3985. *Chairman*: This particular paragraph of course refers only I think to automatic adjustment, does it not?—Yes, indeed.

3986. I think we must not lose sight of that one.—In relation to what Mr. Gunlake said a moment ago, it certainly has been the Government's view in relation to remuneration at the higher levels of the other public services that the case for frequent adjustments was much less strong than it might well be in times of rising prices for those whose pay was little above subsistence level; that it was right that at the higher levels where in any case the remuneration was not so closely geared to the use to which the remuneration was put—was not so closely geared to the cost of necessities—it was right that there should be, even in times of inflation, a greater degree of stability than is practicable at the lower levels. But that is not to say that proper adjustments ought not to be made promptly when the case for them appears. But, as the Chairman says, that is a very different matter from automatic adjustment.

3987. Sir Thomas, I want to come back to this point about the tremendous range of incomes within the medical profession. They are not all in the higher brackets, some are really very high but some certainly are quite low, and on any sort of hardship basis there must surely be a case for dealing with some of the lower paid doctors, however it be, by capitation, by altering loadings, by altering this, that and the other, much more so than in the case of some of the higher paid ones in such times when inflationary conditions prevent a general increase.—I quite agree. These are matters of degree, and I would not like it to be thought that I think of all doctors as being extremely well-to-do men. I quite realise there is an extremely wide range, and that of course was no doubt the very consideration that was in mind when the last adjustments were made where, if I remember rightly, over some part of the field at any rate they were made either more promptly or they were higher at the lower levels, precisely for that kind of reason.

3988. Yes, I think the distribution of it was negotiated, was it not?—*Sir John Hawton*: There were two things, if I may say so, in the medical profession. Your point has been met partly by the loadings in the case of the distribution of the pool capitation fee for those who would otherwise have been lower earning and, in the case of the hospital staff, a 10 per cent. advance was given instead of the 5 per cent., pending the report of this Commission. So I think to some extent your point has been met temporarily until we have the benefit of your recommendations.

3989. Up to a point. We will leave the hospital service on one side and we will just talk about the general practitioner side on this. I would suppose that the general practitioner's expenses have continued to rise, whether it is for paying a receptionist or buying furniture or anything like that, regardless of how many patients he had on his books at that time. The fact remains that from 1952 until the interim award in 1957 the lower paid general practitioner just as much as the higher paid general practitioner had not received anything—is that correct?—*Dame Enid Russell-Smith*: No, not quite. What we pay into the pool for expenses is the actual expenses, a little bit in arrears, but that is a constantly altering figure.

3990. Yes, but the actual expenses are then paid out at so much per head; they are paid out on a capitation basis?—That is true; they are paid out on a capitation basis, but the central pool has gone up consistently with the increase in expenses.

3991. Dame Enid, the point was that if each general practitioner's expenses have gone up say £100 because of having to pay more to the receptionist, more to the nurse and more for the surgery, the man with a list of 1,500 people only gets one half as much, or about one half as much, as the man with a list of 3,000 people towards those increased expenses.—That of course is a question of distribution, is it not? The only point I was trying to make was that it is not fair to say that there has been no addition between 1951 and 1957 in respect of increased expenses for general practitioners.

3992. I appreciate that. How much has the percentage gone up?—May we put that figure in to you?

3993. Yes please. But in any case it is still the position that when we are talking about the unwisdom in times of inflation for the people who are very far from the subsistence level having an automatic adjustment, and if we are thinking of doctors and their particular standard of living that they have to maintain, there may have been some who were far above that level, but also there may have been some who were very near it. And nothing, as far as I know, was done at all from 1952 to 1957 that helped those latter ones particularly.—No, that is true, but under the interim award in 1957, as the Secretary has mentioned, not only was an increased percentage given to the lower paid hospital doctors, but when we came to distribute the 5 per cent. to the general practitioners we put 1s. 6d. on the loadings and 1s. on the capitation fee, which meant that proportionately more went to the medium sized lists.

3994. We missed that point before on the loading. You do regard a medium sized list as from 501 to 1,500; why do you not take the thousand people from 1 to 1,000 instead of 501 to 1,500?—Because there are a number of types of doctors with very small lists who cannot be regarded as in full-time practice. There are, for instance, a number of women doctors, married, who are perhaps in partnership with their husbands but have a very small list; there are a number of old doctors in semi-retirement; and these particular types of practitioner were regarded by the combined Working Party of the Department and the profession as not being fully effective whole-time general practitioners.

3995. I know, but the doctor with 1,200 people on his list, for instance, only gets a loading on 700.—Yes, but it was thought that while that was perhaps a disadvantage it would be a far worse abuse if the full loading had been given on these very small lists to people who are hardly in effective practice and who do not bear an equal share of the collective responsibility accepted by the profession for the whole population. The position of the newcomer is met partly by the initial practice allowance—that is, the newcomer in fully effective practice.

3996. With the newcomer I agree that is so. This all has a bearing on this

question, and I have received the impression that people tend to think of doctors as all in the higher bracket group with an average, in the case of general practitioners of £2,200 or more, whereas there must be plenty who are quite a bit below that.—We are very conscious of it, Sir. For instance, there is no retiring age for general practitioners and there are a large number of very elderly doctors who are really almost semi-retired, and we are very conscious of the existence of these special groups. I am now able to give you the figure for the percentage increase of expenses. Between 1952/53 and 1955/56 expenses had increased by 25 per cent., and the sum put in to the central pool in respect of expenses was of course increased in the same way.

3997. That is a very substantial increase, and it did mean that the man with the comparatively small list got a very much smaller sterling contribution to his increased expenses than the man with the big list?—It did, but the man with the very small list would not have anything like the same expenses.

3998. I am not talking about the very small lists, but the people say with between 1,000 and 1,500 on their list. When a doctor gets up to 1,500 he has the full loading, does he not?—He has the full loading, yes.—*Sir Thomas Padmore*: I suggest, Mr. Chairman, that the position is that so far as practice expenses have gone up in the period to which you have referred, the Government has reimbursed that amount; but it may be that, as a result of the system, the money has not gone very accurately to the people who in fact were incurring the additional expenses.

3999. That is my point. We feel sure the system would result in the reimbursement of expenses properly incurred in total however clumsily, but not in the proper reimbursement of individuals. It is a total sum divided on the assumption, subject to this loading, that each individual patient in the country attracts an equal amount of expense, which is most unlikely.—It is most unlikely both in relation to the basic expenses and in relation to any increase that may take place over a period.

Chairman: Yes, exactly.

4000. *Mr. Gunlake*: May I go on, Sir? We have the Treasury on their

feet, if not on their toes, and there are one or two further questions I would like to ask. I am looking at paragraph 18. I would like a little help, if I might have it, on this figure which you have seen fit to put in here of £20 millions a year. First of all could we know exactly what the coverage is? It includes of course general practitioners. Does it include the specialists, and does it include the dentists?—I think this was for general practitioners only.—*Sir John Hawton*: I can answer that one; it does include the medical profession in the Health Service, that is to say, hospital staff and general practitioners, but not the dentists. The claim in this case was at that time from the medical profession.

4001. That I think explains the nature of the figure, but it does not of course at this stage put any meaning on it, and that perhaps is still a matter for the Treasury to help us with. *Sir Thomas*, you and I who have spent all our lives looking at figures are not impressed by a figure merely because it has seven noughts in it; it has no meaning unless it is related to something, has it?—*Sir Thomas Padmore*: No.

4002. *Mr. Gunlake*: I have been trying to relate this to something to put it into some kind of perspective. You dislike, I gather, relating it to the gross national product for reasons which you mention in paragraph 151, so if I mention that I think it is roughly one-tenth of one per cent. of the gross national product you probably will not comment on that. Could you tell us what percentage roughly this £20 millions a year is of the total gross cost of the Health Service, for example?

Chairman: Do you mean the total cost of the medical part of the Health Service—excluding the dentists?

Mr. Gunlake: Yes.—Do you mean remuneration?

4003. No.—You mean the total cost of the Health Service as a whole?

4004. Yes. Gross, before deducting charges.—Hospitals and everything?

4005. Yes. Can you give me the figure roughly, just to get the order of magnitude.—It is of the order of £700 millions, a little more.

4006. Then it is something like 3 per cent. I just wanted to try and put the thing in some kind of perspective because

a figure by itself has no perspective. From the point of view of the Treasury, as I understand it, this figure would have two viewpoints from which it would have to be looked at; firstly the finance point of view and secondly the economic point of view. From the point of view of finance, if this additional load were put on to the cost of the Health Service it would have to be found in one way or another by the Treasury. It would mean either an increase in the weekly stamp, or, if that method were not considered right, there would have to be an additional sum raised by Parliament in the usual way—is that right?—Or a diminution in the extent of the Service.—*Sir John Hawton*: But surely the alternatives are infinite. You can impose charges for any part of the Service. The weekly stamp has no particular significance; it is only one factor and rather a minor factor.—*Sir Thomas Padmore*: In fact you have either to raise it by some form of charge, to raise it by some form of taxation or to borrow.

4007. Thank you, that helps me with my next question which was concerned with economics and more particularly with econometrics. Was it one of your purposes in inserting this figure to try and give some indication of the extent to which it would add to internal inflationary pressure?—*Sir Thomas Padmore*: I do not think so. We put the figure in because we thought the Commission might be interested in it. It is not a big figure as these things go; it is not a big figure in relation to total Government expenditure, still less a big figure in relation to the total gross national product. On the other hand, it is by no means negligible. We have just had a Budget in which the Chancellor of the Exchequer after scraping around has managed to make certain remissions in taxation, and I think he regards them, and I think everybody else regards them, as not by any means negligible. He has given away this year in taxation £50 millions. Against that sort of background a figure of £20 millions although not a very large figure is, I suggest, not by any means a negligible figure in relation to the national finances.—*Mr. Winnifrith*: The context of this paragraph was that it was thought in an economic crisis in the summer of 1956 you could not do anything here. I think the only point of sticking in £20 millions was to show it

was not the sort of sum you could just laugh off.

4008. Then you were thinking of inflation?—*Sir Thomas Padmore*: If you like we were, but if we were thinking of inflation we would have taken it further than that. There were reasons at that time why the Government would have taken the same view as it took about medical remuneration about any pay increase in the public services whether the amount of money at stake from the point of view of the Exchequer was significant or not. It did, for instance, take that view about certain members of the judiciary, where the cost in terms of what was involved for the Exchequer was absolutely negligible. But nevertheless the Government said: "We have a policy in relation to this; rightly or wrongly, we do not think it right at this time to change remuneration at this sort of level in the public service." That was the view they took about the judiciary and others; it was the view they took about the doctors, and they would have taken that view I am sure if the figure of £20 millions had been £200,000. The fact that it was £20 millions, was, if you like, an added reason for taking that view in this particular instance.

4009. Thank you, you have relieved my mind a good deal. I never supposed that a figure of 2 followed by seven noughts was put in to frighten the Royal Commission. Am I right in thinking that getting on for one-half of this sum would in any case have been taken away in the form of tax and super tax at the current levels of remuneration about which we are speaking?—I should think so. I would have thought rather less than half but a substantial amount of it, yes.

4010. *Chairman*: Can we go back to the later parts of your memorandum again now, unless you want to add anything to that?—No, I do not think so, thank you.

4011. We come to this part about the present methods of settling the remuneration, and I think broadly you feel that the methods are there and are capable of working and in fact very often do work for all the minor and more detailed matters. The main question concerns the setting up of some method of dealing with the basic questions, is that right?—*Sir John Hawton*: You are now on question (20)?

4012. Question (20), paragraph 195.—We have here—he has not yet joined in—Mr. Allen who manages all the Whitley and negotiating side of our Service arrangements.

4013. You are not to be confused with the B.M.A. Professor Allen?—*Mr. Allen*: Strictly not.

4014. But I believe you did in fact learn under him, is that right?—That is so.

4015. Really we can assume that all the ordinary matters, the day to day matters or the month to month matters that come up and are dealt with are capable of being dealt with under Whitley or other machinery?—Any such matter affecting remuneration is capable of being dealt with there.

4016. And is in fact, without more than the ordinary amount of negotiating difficulties and troubles?—Yes.

4017. The B.M.A. have sent us a document recently which we have not had a chance of talking to them about. I do not know whether you have seen that document, Sir John?—*Sir John Hawton*: I have not seen it. Dame Enid has it.

4018. They are recommending to us that a standing committee on medical remuneration be appointed by the Prime Minister. This would be a small committee under the chairmanship of an eminent person, possibly with a legal background, its composition agreed with the medical profession. The terms of reference, also to be agreed with the profession, would be to review remuneration in the profession at annual intervals and to make a report to be issued publicly each year, the basis of the annual review to be movements in an index, the details of which would be agreed between the Government and the profession. The Council has taken expert advice and has been assured that such an index could be devised without difficulty. I tried to read this to see whether it bore the interpretation of being an index of remuneration in other comparable professions, or whether it only bore the interpretation of being an index of the change in the value of money, and I think it bears the latter interpretation. Would you have any views on the practicability or acceptability of such a proposal? I should add that of course it is said, I think quite clearly, that both sides would undertake to accept the

recommendations of the committee, which is material.—*Sir Thomas Padmore*: Of course it is perfectly possible to produce value of money indices of various kinds; there are already some in existence. A much more difficult thing would be to produce an index of remuneration, certainly remuneration at particular levels, salaried or professional remuneration. Indeed, as far as I am aware, no such index exists at present, and I imagine there would be great difficulty in producing one that was worth very much. But indeed we have the strongest views about any idea of linking remuneration in any public service to any index of either of those kinds. Perhaps I might ask Mr. Winniffrith, who rather specialises on some of these things, if he would take this up.—*Mr. Winniffrith*: I do not think I have much more to say than has been said, Sir, except that apart from all the evils of working on fixed lines like that, it seems scarcely necessary to have such an eminent committee to work such machinery. You are really making them into a combination of a calculating machine and a rubber stamp. You could have a much more humdrum machine for arriving at that result.

4019. Do you mean the Treasury? (*Laughter*)—I think that is just about our level!

4020. I want to come back on what Sir Thomas said for a moment. I can quite see your complete and determined objection to any automatic adjustment of remuneration—which, by the way, the B.M.A. do not propose should take place too rapidly or too regularly—but that is a slightly different matter from any such one based on any index relating to the value of money or the cost of living. If it is related to remuneration received in comparable professions I did not think you had such a strong objection?—*Sir Thomas Padmore*: I do not think we would have the same objection in principle. The objections are really of a different character. The objection to tying the remuneration of any public service to variations in the value of money are simply the objection to insulating one public service against changes in the value of money when other public services are not in the same position. Quite clearly, if you are to have a system in which fair comparisons prevail, at any rate among the public services, you must

either link none of them automatically to the value of money or you must link them all. If you do link them all you are then in a situation in which the public services as a whole might well be found to be in a privileged position in relation to the rest of the community. That is the nature of our objection to a link to an index which shows changes in the value of money. I think the objections to an index, which truly reflected changes in remuneration both in the public services and outside them for the sort of people who might fairly be compared with either the services we are talking about or the public services generally, are different. I think they are simply the practical objection that we find it very difficult to believe that it would be possible to work the principle of fair comparison by reference to an automatic formula of that kind, that it would be possible to produce an index that really did fairly reflect the rather wide variety of information that would go into building it up. I would have expected that, given the progress that has been made in recent times in statistical matters, if it had really been thought practicable to produce an index of that kind—a good and reliable index—such an index would either have been produced from official sources or from private sources before now; and that the reason why such a thing does not exist is precisely because it is very difficult and perhaps impracticable to do with the hope of a really satisfactory result emerging.

4021. I quite see that. I am sure that there is not such an index now. On the other hand, whether you take the Coleraine Committee or any other body, they would have to have something to work on if they were to go on this principle of fair comparisons.—I agree, but that really is at the basis of what Mr. Winnifrith was saying; that is why you want a Coleraine Committee. If you could have a reliable index that would tell you the answer reading it off like a slide rule you would not need a committee. It seems to me if the principle of fair comparison is to be applied in the Civil Service or anywhere else there will be, and will continue to be, scope for the exercise of a very considerable degree of judgment by wise men looking at all the circumstances,

and certainly not being guided primarily or perhaps indeed at all by anything in the nature of an automatic index.—*Mr. Winnifrith*: Perhaps I might say the Coleraine Committee does not work in that way. The Coleraine Committee is not guided by an index; it is guided by the principles laid down by the Royal Commission on the Civil Service on how the Civil Service should be remunerated, and that does mean they are finding out for themselves what is being paid at any given time to people who are doing what they think are roughly equivalent jobs. Incidentally, perhaps I may correct one point made by the B.M.A. The B.M.A. say they used the facts secured by the Civil Service Pay Research Unit; as far as I know that is not so. In all their activities up till now the Coleraine Committee have relied on information which they have got for themselves.—*Sir Thomas Padmore*: I should like to make it plain, Mr. Chairman—perhaps it is already, forgive me if it is—that although we say these things in criticism first of all of the use of an index that purports to measure or indeed does measure changes in the value of money, and secondly of an index which we think could do no more than purport to measure the application of the doctrine of fair comparisons, we have nothing to say in criticism of the suggestion which was put forward to you in this document that there should be—and indeed your terms of reference refer to it—some standing machinery for keeping this matter under review, possibly by the institution of something of the kind that exists for the Civil Service in the shape of the Coleraine Committee, or something different if you think fit.

4022. There seems to be at least one important difference between the Civil Service and the medical profession and that is there is not this long history of suspicion that seems to exist among at least some of the leaders in the medical profession. You may get dissatisfaction in the Civil Service, but there is rather more than that here. There has been suspicion of motives I would say within the medical profession, and I would think there has got to be not merely a committee of thoroughly independent and praiseworthy people but there would need to be some definition of criteria that these people would have to take into account if they were to get the full con-

fidence of the profession. What do you feel about that?—I would agree. I do not know as to the question of confidence. There has very commonly been a feeling in the Civil Service over the years that it was treated as a guinea pig by the Government in matters of remuneration. Although I think now, largely as a result of the Priestley Commission and what has followed it, the atmosphere is good, it would be wrong to suppose that there has always been a high degree of confidence and goodwill between the Government and its employees in these matters of remuneration. But, however that may be, I would respectfully agree that if this Commission were to propose some machinery of the kind we have been talking about for keeping medical remuneration under review it would be a valuable thing that such a committee should not, as it were, be left to evolve its own principles as it went on and thus in a way to do part of the work of this Commission over again, but that it should be given as much guidance as possible, by the Royal Commission, and given as clearly defined a job and as much in the way of principles as it proves practicable to devise.

4023. Thank you very much; I see our task gets no easier! I just want to ask you a question about arbitration. You have it quite clearly established in your minds that compulsory resort to arbitration is suitable up to a certain level and that above that level, roughly represented at a sort of managerial level of salaries, it is not appropriate.—That is a doctrine we have always held in the Civil Service, and it is the doctrine we tendered in evidence to the Royal Commission on the Civil Service. On the whole I think it is fair to say it was accepted by them and that it was as a result of that they recommended the creation of this special machinery for the higher reaches of the Civil Service.

4024. You have within the Civil Service again a wide variety of salary levels, and a lot of them are below the £2,000 mark or thereabouts up to which arbitration is appropriate. What about doctors who are below that level? Do you feel that doctors have to be taken all as one class and as though they were all above that level?—*Mr. Winnifrith*: I see no reason at all why you cannot split the doctors up in units in the hospital service.

4025. In the hospital service, yes.—And have a bar at a suitable point there. It seems almost impossible to evolve a similar structure for the general practitioners.

4026. That is one of the things we are wondering about because it does seem as though the quite considerable number of general practitioners who earn a good deal less than your arbitration figure—it is a rather arbitrary but probably acceptable limit—are debarred from the benefits of arbitration because some of their colleagues are above it. Have you given any thought to that matter? Have you just realised it is a difficulty?—No, I have thought about it for a long time I am afraid only to conclude that it is insoluble. I do not see how you can take any part of that entity in isolation.—*Sir John Hawton*: One of the difficulties, Sir, would be that the general practitioner, who is drawing his remuneration for a number of patients from a pool, will vary his remuneration more or less all the time and you would not know whether in the one year he was within the arbitration limit and whether in the next year he was outside it. With salaried employment you know you have a whole class of people who are in it or out of it. It is just as if you were dealing with a self-employed shopkeeper; you do not know what his fixed income is. That would be a practical difficulty.

4027. I think there is no doubt about the practical difficulty. That is why it has not been done, no doubt. The question then becomes: do you want to sacrifice the whole Government principle because a lot of people are below the arbitration limit and you can only deal with them provided you bring the other ones in, or do you want to keep the whole principle and thereby prevent the lower paid ones from having the benefits of arbitration at a time when other people are going up and they have not gone up for five years? Is not that the dilemma?—*Mr. Winnifrith*: If you had the advisory committee there is no earthly reason why they should not intervene.

4028. *Mr. Bonham-Carter*: *Mr. Winnifrith*, are we missing something here by not looking at the question of status, because status comes into the Spens Report and comes in I suspect in this whole field a great deal? Would it be possible to arbitrate on people at

a higher level? In your experience has it been done?—There have been some very odd references. Once the town clerks managed, through using the Industrial Disputes Tribunal procedure, to get their claim into that Court and it was settled there. I do not think anyone thought that was a very satisfactory way of settling salaries at that level with all the complications that exist when you get to that level.

4029. Forgive me—I am not attempting to be anything but perfectly serious—but would senior civil servants care to be adjudicated on in a Court? I am sure they would not.—I am sure they would not and I think the B.M.A. took precisely the same view about doctors.

4030. Therefore what we are talking about as regards the lower paid doctors is merely the young starter in the general practitioner field, and you cannot legislate differently I submit, can you, merely because he is a young man at the beginning of his career?—I would hope it would be settled otherwise, and of course one ought not to arbitrate at all if possible. Any settlement that can be made by negotiation and agreement is far better. I do not see anything positively indecent in, say, the junior hospital grades getting arbitration any more than some of our junior grades in the administrative class.

4031. I took your point very well when you mentioned the hospital service in this connection to begin with, but on the general practitioner side they are really all the same, although some are lowly paid and some have reached the higher levels.—*Sir Thomas Padmore*: I think that is so. One must I think recognise that, although there may be marginal questions in relation to loadings and that kind of thing, as long as the system remains a capitation system any arbitration about general practitioners' remuneration is really primarily an arbitration about the capitation pay that goes into the pool. And I do not see how you could have an arbitration about half of that or about the capitation payments to those who receive smaller amounts and exclude the rest.

4032. *Chairman*: There is one other point on this, Sir Thomas. Would you agree that people ought not to feel that they were being done out of something by being denied recourse to arbitration; that alternative methods of settling it

ought by and large to produce the same sort of result, if it is fair, as they would have done if they had gone to arbitration?—I would readily agree in principle, and it is one of the reasons why we welcomed the recommendation of the Royal Commission on the Civil Service for the setting up of the Coleraine Committee. To me personally the idea that when there is a dispute there should not in the last resort be an umpire is repugnant. I think that any employer unable to reach agreement with his employees ought if possible to be willing to submit the disagreement to some kind of arbitration. But there are certain limitations. There are the limitations of the actual system of arbitration as we know it in this country in its application at the higher levels—certainly in the public services where we think it would be inappropriate—and it is because of those limitations that we have in the Civil Service an alternative system which differs from arbitration in a number of ways, but differs perhaps more than anything in that it is advisory in its findings and not binding, and also in the extent to which it cannot be set into motion by a claim on behalf of one of the parties. We would have thought that both of those two features ought also to be features of any similar system of continuous review that might be suggested by this Commission for the medical and dental professions.

4033. You would feel, would you Sir Thomas, that an advisory system only continues to command the confidence of anyone if the advice is usually taken?—I would expect so. And I must say we as civil servants feel fairly confident that it will be very rare, if it happens at all, that the advice of a body like the Coleraine Committee would not be taken.

4034. Then you mentioned another feature, that one of these reviews can be set in motion on the instigation of the committee itself—they do not need anyone else to ask them, which is a good thing?—Yes.

4035. Would it, almost as a by-product of that, mean that there would be rather less stating of *ex parte* cases that exaggerated differences and tended to prolong discussions? Would you hope that that would happen? Public hearings in an arbitration *per se* probably seldom tend to produce unity among the

people and have not done so in this case.—I would hope that any such committee for the medical and dental services would determine its own procedure. It might well be that the extent to which it would wish to hear a case argued by this side or that, the extent to which it would wish to have information and memoranda, might vary from time to time, but that it should be in charge of its own procedure just as the Coleraine Committee is.

4036. Would you also feel—I think it follows from what you were saying—that conditions as between any two professions or occupations change from time to time too, and that it is impossible to form any absolutely fixed and static relation between any two occupations without ensuring the ultimate extinction of one or the other—is that an exaggeration?—I entirely agree. "Extinction"—I do not know; I hope it will not come to that!

4037. I was not thinking of the Civil Service. I think we have covered the points I wanted to raise on that.—*Mr. Winnifrith*: Could I say one other thing about the advisory committee idea. I am sure one of the reasons why at the moment at any rate suspicion in the Civil Service about the goodwill of their employer is less is because we have got this committee, and the reason why the committee is such a protection to us is that it is so palpably not our creature. It is broad based, it has almost every kind of profession represented on it except the civil servant. Although the staff are consulted about the names which the Prime Minister has in mind, the Prime Minister makes the appointments; they are in no sense joint appointments, and that quite palpably independent nature of the body is a great source of strength, because obviously the more independent it is the less likely any Government is to disregard its advice.

4038. Would you also think, *Mr. Winnifrith*, that it is perhaps more likely that the Civil Service at the top will be more aware of the impartial and independent nature of some people collected from outside than can really be expected in a special profession like the medical profession? I think it might be a good deal more difficult to get people who were accepted in advance of their findings.—Yes, I think I would agree. There

is, of course, always this idea that no one knows anything about a profession who has not had some intimate connection with the profession, but I think that is overdone.

Chairman: Yes, I do not think we should dispute that with you.

4039. *Mr. Bonham-Carter*: We are agreed, are we not, *Mr. Winnifrith*, that failure of the Government to take the advice of the Coleraine Committee, except in most difficult circumstances, will destroy confidence in that Committee very quickly. That must be a personal view I am asking you for.—Indeed I entirely agree, but I would also say, and this point came up yesterday, that any kind of public service must expect at times to be caught up in some ghastly crisis. When that happens it does not matter who gives the advice. Advice may have to be disregarded.—*Sir Thomas Padmore*: But this is more really a question of form than of substance, and it is the form, the formal fact, that both in relation to the Civil Service and in relation to other public services all governments hitherto have said: "On these matters of remuneration at the top levels we must have the last word; we are not going to be told by anybody that we must do so-and-so." In practice, in the case of the Civil Service, which has had this kind of machinery, not in this form, for a very long time—because from time to time we have had Royal Commissions and we have had other committees—there has been no instance hitherto where the Government has not accepted the recommendations emanating from bodies of that kind. Although, as *Mr. Winnifrith* says, sometimes there is a slight pause if the recommendations come on a rather untimely occasion, as happened with the committee which was presided over by Lord Chorley which made recommendations about rates of pay at the top of the Civil Service a few years ago; there was a delay then of a bit under a year or so.—*Mr. Winnifrith*: We got caught up by devaluation.

4040. *Chairman*: There were just one or two other rather minor points that relate to dentists and I think we can deal with them very quickly.

The dentists do complain that when they are away from their surgeries carrying out work necessary for the adminis-

tration of the National Health Service on appeal panels and committees—the appeal panels seem to be the important ones—their earnings are reduced because they are not at work. Have you any idea to what extent dentists are involved in work of this kind, and do the Departments consider there are any special arrangements that should be made to meet this difficulty?—*Sir John Hawton*: On your second point, we do make arrangements and we do take into account the loss of time; not, I agree, perhaps equivalent to what would have been earned at the chairside.

4041. The same sort of rates?—We do, of course, have to remember that there are a great many people involved in this kind of work—this is not peculiar to dentists. There are a number of voluntary people who seem to be willing to give time freely and who are in their own way just as busy, if not busier. As to your first point, the extent to which it happens, how one can measure that I do not know.—*Dame Enid Russell-Smith*: We might be able to get out some estimates.—*Sir John Hawton*: Obviously, it is difficult to know.

4042. I think it would be useful to know since the dentists make the point. It would be useful to know whether it is a material one or really rather a small one.—*Dame Enid Russell-Smith*: Could we know exactly what the bodies are in which you are interested because there are such a lot on which dentists serve, and different considerations arise.

4043. We will ask the dentists. It was the B.D.A. who raised that point that they do put a lot of time, for instance, on these panels.—There is one point in relation to this question and that is while such work is greatly to the benefit of the Service and, therefore, to the patient and the dentists who participate in the working of the Service, it is also to the benefit of the profession.

4044. Yes. Do the Departments agree with the suggestion that came from the McNair Committee that there should be a recruitment of about 800 dentists a year for a long time ahead? Is that view accepted?—*Sir John Hawton*: Yes, that view has been accepted.

4045. Have you any idea as to when that will relieve the shortage of dentists?—It depends so much on the capacity of the dental schools. We are trying by

consultation to see what we can do about it.

4046. Even when you have raised the capacity of the schools, and the first 800 come out, that will not put the country right for the supply of dentists. I wondered how many years you think it will take?—The number we want is a total of 10,000.—*Dame Enid Russell-Smith*: 20,000.—*Sir John Hawton*: The total that we are told is needed is 20,000 but you have to subtract what we have got now from that. 20,000 is the total required.

4047. Perhaps we can do a bit of arithmetic ourselves on that. Then, we have another question. How frequently do you recalculate the level of dentists' expenses?—*Dame Enid Russell-Smith*: We again get the actual expenses.

4048. How frequently?—We have had two main inquiries, one in 1952 and one in 1955-1956, and we are now doing an annual sub-sample.

4049. And the annual sub-sample will provide a running check on which you can work fairly often?—Yes.

4050. Are there any regular arrangements for periodic inspection of dentists' surgeries to see how far they maintain a reasonable standard?—There are no regular periodical inspections but dentists' surgeries are visited in two ways. Firstly, it is part of their terms of service under the Executive Council that they are to maintain proper surgeries and on any complaints the Executive Council would arrange to inspect. Secondly, dentists are visited by the Regional Dental Officers for various purposes and they see the surgeries then.

4051. Have you any other special points you want to make, *Sir John*?—*Sir John Hawton*: I do not think so.

4052. Well then, it remains for me to thank you very much for coming. I think I should perhaps stress one thing, because there was a point referred to two or three times yesterday by *Dame Enid*, about your being prepared to consider any system of distribution that was agreed with the profession. Of course, we regard our terms as a bit wider than that, not as arbitrating on the points of difference between you and the profession, but, we hope, producing something constructive that might not have happened to have occurred to the Government or profession as right. We

do not regard ourselves tied simply to the settling of differences.

I have no doubt at all that we shall want to see you again at a later stage when we have more clearly focused on more direct points, probably for less time and possibly with much less warning and briefing and preparation. Whether you think that an advantage or not, I do not know.—We have the advantage of a

brief on this occasion but sometimes it can be a handicap rather than an advantage!

4053. In any case, I think we have given you a rather long and concentrated time and I would like to thank you for the very patient and thorough way in which you have answered almost all our questions.—We should like to thank you also for being so tolerant.

(The witnesses withdrew)



Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

16—17

Sixteenth Day, Thursday, 24th April, 1958

Seventeenth Day, Friday, 25th April, 1958

WITNESSES

Royal College of Surgeons of England

Royal College of Obstetricians and Gynaecologists



LONDON

HER MAJESTY'S STATIONERY OFFICE

1958

FOUR SHILLINGS NET

Witnesses

ROYAL COLLEGE OF SURGEONS OF ENGLAND

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SIR HARRY PLATT, BT., F.R.C.S.
HAROLD EDWARDS, C.B.E., F.R.C.S.
SIR WILFRED FISH, C.B.E., F.D.S.R.C.S.
SIR WILLIAM KELSEY FRY, C.B.E., M.C., F.D.S.R.C.S.
PROFESSOR R. V. BRADLAW, C.B.E., F.D.S.R.C.S.

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ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

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J. H. PEEL, F.R.C.S., F.R.C.O.G.

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

SIXTEENTH DAY

Thursday, 24th April, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

MR. I. D. MCINTOSH, M.A.
SIR DAVID HUGHES PARRY, Q.C.

PROFESSOR JOHN JEWKES, C.B.E.

SIR HUGH WATSON, D.K.S.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

EXPLANATORY NOTE BY THE ROYAL COMMISSION

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence, to all representative medical organisations:—

- (i) The quality and quantity of recruits (a) offering themselves and (b) accepted for training as medical students.
- (ii) The quantity and quality of newly qualified doctors.
- (iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.
- (iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).
- (v) The position and prospects of a newly qualified doctor.
- (vi) Any trend to excessive resort to certain branches of the profession at the cost of others.
- (vii) The relative advantages and disadvantages, financial and otherwise, of service as:—
 - (a) a principal in single-handed general practice,
 - (b) a partner in general practice,
 - (c) a whole-time consultant in the National Health Service,
 - (d) a part-time consultant with the maximum number of sessions,
 - (e) a part-time consultant with only a few sessions,
 - (f) a Senior Hospital Medical Officer,
 - (g) a doctor in any other sort of practice or employment.
- (viii) The difficulties encountered by members of the registrar grades.
- (ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.

- (x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.
- (xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.
- (xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service.
- (xiii) Any anomalies in the methods of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume.
- (xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.
- (xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.
- (xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.
- (xvii) Special considerations of which account ought to be taken in discussions of medical remuneration.
- (xviii) Specific proposals for medical remuneration.
- (xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.
- (xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.
- (xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

EVIDENCE SUBMITTED BY THE COUNCIL OF THE COLLEGE TO THE
ROYAL COMMISSION ON DOCTORS' AND DENTISTS'
REMUNERATION

PART A—MEDICINE

The Royal College of Surgeons of England

1. In 1800 the Company of Surgeons of London was reconstituted by Royal Charter as a Royal College of Surgeons. In 1843 the name was changed to The Royal College of Surgeons of England. The College is governed by a Council of twenty-four Fellows elected by postal ballot from the surgical Fellows of the College, of whom there are over 4,000 scattered throughout the world. In addition, representatives of various special branches of medicine and surgery also serve on the Council. There is within the College a Faculty of Dental Surgery and a Faculty of Anaesthetists.

2. The College is a scientific and educational body. Its activities fall into three main headings—(a) examinations; (b) research; and (c) postgraduate education.

Examinations

3. The College as a licensing body grants conjointly with the Royal College of Physicians of London the qualifying diplomas of L.R.C.P., M.R.C.S. Study for these diplomas must be taken at recognised medical schools and hospitals. In addition, the College also grants conjointly with the Royal College of Physicians diplomas in the following specialties: Anaesthetics, Child Health, Industrial Health, Laryngology and Otology, Medical Radio-Diagnosis, Medical Radiotherapy, Ophthalmology, Pathology, Physical Medicine, Psychological Medicine, Public Health, and Tropical Medicine and Hygiene. The College also grants the Licence in Dental Surgery. There are over 25,000 Members and Diplomates of the College.

4. The College grants three Fellowships (F.R.C.S., F.D.S.R.C.S. and F.F.A.R.C.S.) For each Fellowship candidates have to be in possession of a recognised medical or dental qualification before entering for a Primary Examination in the basic medical sciences. They must have completed appropriate recognised hospital appointments before sitting for the Final examination.

Research

5. Research is carried out in Surgery and allied subjects in the laboratories of the main Departments of the College, which are Anatomy, Physiology, Pathology, Pharmacology, Ophthalmology, Dental Science and Anaesthetics, and also at the Buckston Browne Farm at Downe, in Kent. Each Department has a Professor or Director in charge, together with appropriate staff.

Postgraduate Education

6. Postgraduate education in the basic medical sciences is carried out in the College in the Institute of Basic Medical Sciences which is controlled jointly by the College and the University of London. Teaching in surgery and in the major specialties is carried out in organised courses in the College itself, and by special arrangement in various hospitals in London. The courses vary in length between two weeks and two years. Over a thousand postgraduates are enrolled in the College every year.

Consultants and the National Health Service

7. When the consultants and specialists of the nation reluctantly agreed to enter the National Health Service, they did so on certain assurances. (1) That no attempt would be made to introduce a universal full-time hospital consultant service; and (2) that the findings of the Spens Report (1948) would form the basis of all arrangements for future remuneration.

8. As regards the first proviso, although in some Regional Boards minority groups have from time to time advocated an increase in the number of full-time appointments, the present day hospital staffing is based predominantly on the part-time system. This arrangement continues to command the allegiance of the vast majority of the consultants in this country, and the Royal College of Surgeons stands strongly behind this attitude for reasons which are set out later in this document.

9. The Spens Report envisaged the maintenance of the economic position of consultants and specialists in accordance with changing money values. The salary structure recommended in the Report represented an attempt to equate remuneration by salary with the net earnings in private practice as revealed in an analysis by a distinguished statistician of a significant sample of consultants' incomes in the year 1938-39. It was clearly stated that the salaries recommended in 1948 were based on the 1939 values of money. But it was not until 1954 (four years after the Danckwerts Award to general practitioners) that the first adjustment was made. In this *ex gratia* adjustment whereas the remuneration of junior officers in the hospital service was in some cases substantially augmented, some senior consultants with the highest distinction awards found that their remuneration had been ingeniously "abated". A further increase made on May 1st, 1957, showed that the hospital salaries of part-time consultants holding a 4, 5 or 6 sessional contract and receiving an A merit award, and those with a 5 or 6 sessional contract and a B award, were now less than the amounts in the corresponding grades previous to 1954! Such derisory increases clearly indicate a cynical disregard of the claims of the hospital consultants to a betterment award which should go some way at least towards closing the gap between the 1939 and 1957 purchasing power of the pound sterling.

Economic and Social Status of the Consultant

10. Although the Royal College of Surgeons is primarily concerned with the maintenance of the academic standards of surgery (both general and special) and of anaesthetics and dental surgery, it cannot ignore the fact that the material rewards open to surgical consultants profoundly influence both the quality of recruitment to the art of surgery and the way of life of the practising surgeon.

11. The education of the would-be surgeon is long, arduous, and expensive. After qualification a three-year period of postgraduate study and practical experience is demanded before the surgical aspirant is allowed to sit for the final F.R.C.S. examination, but in fact the average period is five years. Moreover, he cannot enter for the final until he has passed a primary examination in the basic medical sciences—a formidable hurdle to be negotiated. If successful in obtaining the F.R.C.S. diploma he will still need to undertake one or two further years of surgical training before he is likely to obtain one of the limited number of higher training posts in the rank of *senior registrar* at a teaching or non-teaching hospital. A minimum period of four years in these higher training posts is required before the young surgeon is considered fit to undertake independent responsibility as a consultant, and for some, the training may be prolonged beyond the four years by the valuable interpolation of a period of special experience in a surgical centre in the United States or Europe. The remuneration of the senior registrar in the first few years after the introduction of the Health Service may have appeared to provide a modest security, though with little or no margin for the essentials of a professional way of life. But in 1957 the augmented top salary, markedly devalued in purchasing power, now represents a retreat rather than advance.

12. Comparable austere circumstances confront younger surgical consultants in their earlier years. These are men who may have spent six years or even longer as senior registrars before being elected to the visiting staff of a hospital. Augmentation of the basic salary by private practice is often a slow process, and the catchment areas of many hospitals cannot for economic reasons provide a practice on any substantial scale.

13. The modern surgeon works under conditions of heavier physical and mental strain than his early 20th century predecessors. It was well said some thirty years

ago by Sir John Bland-Sutton, a distinguished President of this College, that the prime need of a successful surgeon was "robust health". This is even more true to-day as major operations increase in length and complexity. But the surgeon is not a mere operating machine. The art of surgery looks more and more to the basic medical sciences for its subsistence, and if the surgeon is to keep abreast of advancing knowledge he needs "leisure" to read, to write, and to travel. These are traditional obligations to his art, and they are expensive. The surgeon must therefore be able to look forward to a standard of professional earnings which allows him to incur such expenditure without sacrificing essential family needs. If surgeons are so "squeezed" that these essential activities are no longer possible, then the quality and prestige of British surgery will decline. No civilised nation, least of all Great Britain, can afford to contemplate such happenings with equanimity.

14. Material considerations do not in the end determine the choice of a career in medicine, but members of a learned profession, so arduous in the demands made upon it, quite rightly expect to enjoy a relatively high economic status in society, and believe that the highest rewards should be open to men of outstanding ability as in the Law and other vocations.

Questionnaire

15. The College has selected from the questions submitted by the Royal Commission those on which it feels it can usefully comment.

Recruitment and Maintenance of Medical Students

16. For the past hundred years medical students have been drawn from a variety of social groups. There has always however been a nucleus in all medical schools of students from cultured homes—the children of parents rarely wealthy—e.g. the sons and daughters of doctors and of the vicarage and manse; or from comparable families whose children have been brought up to look upon medicine primarily as a vocation. The higher education of such children has often demanded a willing sacrifice on the part of the parents. Such sacrifices are still necessary to-day, as the gross professional income of the parent too often disqualifies the child for full scholarship grants. This ever-present nucleus has acted as a leaven and has been responsible for the continued high social prestige of the profession as a whole, and above all for the maintenance of medicine as one of the learned professions in the community. Medicine would lose immeasurably if the proportion of such students in the future were to be reduced in favour of precocious children who qualify for subsidies from Local Authorities and the State purely on examination results.

Whole-Time or Part-Time Consultant Appointments

17. Although for economic or other reasons there may be a place for a limited number of whole-time non-academic consultant posts, most consultant posts should be part-time. An exclusive contractual dependence on central government or any of its agencies is not a desirable relationship for members of a self-governing learned profession for whom a substantial measure of independence is vital. This type of freedom means the opportunity and the right to deal with patients as individuals in their own homes and not solely with groups of patients assembled only under institutional conditions. A part-time contract with the maximum number of sessions is the most desirable arrangement for consultants on the staff of the great majority of non-teaching hospitals, and is essential in the smaller centres where private practice is scanty. Furthermore, an appointment of this type means that consultants tend to live near their hospitals, and thus have an opportunity to share in the civic and cultural life of the town or city in which the hospitals lie. A maximum part-time appointment can also provide, both clinically and scientifically, a satisfying career for any consultant who, by reason of the range of experience so offered, feels the urge to take part in clinical investigations, thus adding his contribution to knowledge, and so fulfilling his indebtedness to his art. A part-time contract with only a few sessions is an appropriate arrangement where it is desired to retain the services of a senior consultant. It is an uneconomic arrangement for a young consultant and is therefore not to be regarded as an acceptable basic pattern for hospital staffing.

Registrars

18. Immediately after the war many supernumerary "registrar" appointments were created whose holders were encouraged to undergo prolonged training for a hypothetical number of consultant appointments to be provided by the forthcoming National Health Service. A proportion of these pre-N.H.S. Act registrars have reached the position of highly trained senior registrars of more than four years' standing without as yet having a consultant appointment in sight. There is a moral obligation to ensure their future.

19. The title "registrar" is misleading in that it continues to be applied indiscriminately to senior resident posts essential (as they were in the past) to the efficient day-to-day working of the hospitals, but not all stepping-stones to the limited number of *senior registrar* appointments now regarded as the only true training posts for future consultant status. We are of the opinion that the present-day title of registrar should be abolished and for these men and women the well-established titles of Senior House Surgeon, Resident Surgical Officer, Resident Medical Officer, and so on should be restored. This would make it clear that these men and women are not yet chosen as trainees for consultant posts. The term Registrar should therefore apply in the future only to present-day *senior registrars*.

20. The opportunities for the absorption into practice—both general and specialist—of well-trained registrars and of a proportion of senior registrars, have become severely restricted in the past few years both at home and abroad. The present attitude of general practitioners is to regard a young doctor well trained in surgery as unsuitable to join a partnership. A change of attitude is most desirable. No longer are there careers in the Indian Medical Service, and very few in the Colonial Medical Service.

21. The virtual extinction of the general practitioner-surgeon class has closed yet another avenue. This we regard as a retrograde step, for at many hospitals there is room within surgical teams headed by a consultant for the competent general practitioner-surgeon.

Private Consulting Practice as an Incentive to Entering the Consultant Branch of Medicine

22. The sense of independence engendered by freedom to engage in private practice reflects one of the most cherished traditions of the profession—the doctor-patient relationship. Furthermore, private consulting practice brings a consultant in personal contact with a wider range of social groups in the community. He meets men and women important in public life, in business and the professions, without the embarrassment of a pre-arranged "national" contract. He is free to offer them his skill at times and places suitable to all concerned. Private practice augments a consultant's professional income and is thus one of the important incentives appropriate by long tradition for the free and learned professions. The importance of "differential" rewards was fully realised by the Spens Committee and it was to meet this essential demand that the Distinction Award system was devised. In addition to the incentive to the individual, there is the undoubted value of private consulting practice to the nation, both as regards prestige and the augmentation of the national income by patients from abroad who may wish to come to this country for private treatment.

Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service

23. The present situation as regards the whole-time consultant is inequitable, and should be remedied without delay. It cannot be emphasised too often that the *professional clinical* obligations of the part-time consultant and the whole-time consultant are identical. They are based on a responsibility for patients 24 hours in the day, seven days a week, and 365 days a year, a responsibility interrupted only during periods of leave in which the care of the patient is delegated to a colleague of equal status. For both the part-time and whole-time consultant this continuous obligation

involves the same need for being on emergency call, and therefore the same need for the possession of a telephone; the use of a car; the obligation to attend meetings at home and abroad; the same liability for expenses incurred in the preparation of lectures, articles for the medical press and text-books—and so on. For the part-time consultant, these are overhead expenses and non-taxable. It is not widely known that the whole-time consultant does not receive their equivalent as direct tax-free allowances from his employing authority.

Distinction Award System

24. As far as we are able to judge, the Distinction Award system seems to have worked well and so far has given rise to very little criticism. As we have already said, there must be differentials in rewards in all free professions. Consideration might well be given to extend the system to embrace those engaged in general practice.

Specific Proposals for Medical Remuneration

25. The College has already in an earlier part of this document expressed the view that the existing scales of consultants' remuneration should be reviewed as envisaged in the Spens Report, in order that they should represent equitably the present-day values of money.

Whitley Council

26. We consider that the Whitley Council System, admirable no doubt for a wide range of manual and clerical occupations, is not the proper mechanism for discussions between a free and learned profession and the so-called "employing authorities". It should not be impossible to devise an Arbitration Council of the highest level which would be acceptable to the medical profession.

PART B—DENTAL SURGERY

Preamble

27. The Royal College of Surgeons of England has been actively and continuously concerned with dental education and with the professional examinations taken by dental students for nearly one hundred years. In fact, the College was the first statutory body in the United Kingdom to introduce examinations for a registrable dental qualification. These examinations have been held uninterruptedly since 1860 and more dentists in the United Kingdom have obtained the Licence in Dental Surgery of this College than have taken any other dental diploma or degree. In the years 1950-54 inclusive 1,106 of the 2,736 dentists whose names were added to the Register held this Licence. This extensive connection with the science and the practice of dental surgery was made even closer by the creation of the Faculty of Dental Surgery and the institution of a Fellowship in Dental Surgery by the Council of the College under Royal Charter in 1947.

28. The Fellowship in Dental Surgery is recognised as a higher qualification which most consultants in dentistry in England and Wales would be expected to hold.

29. The Faculty of Dental Surgery was founded to advance the science and art of dental surgery, to encourage study and research, and to protect the rights of dental surgeons acquired by them as Fellows or Licentiates in Dental Surgery of the College. It is governed under the Council by a Board elected by the Fellows and Licentiates and a Dean elected by the Board.

30. Its principal activities are concerned with:—

- (a) the Licensing and Fellowship Examinations and the examinations for the Diploma in Orthodontics,
- (b) courses of instruction in connection with the Fellowship in Dental Surgery and other diplomas of the College,
- (c) special lectures by eminent persons from the United Kingdom, Dominions and abroad,

- (d) inspection of hospital departments in relation to their suitability for post-graduate training,
- (e) representation upon statutory committees for consultant and other appointments in the hospital dental service,
- (f) promotion of research through its Department of Dental Science, and
- (g) advising the Council of the College upon all matters connected with dental surgery.

31. The Royal College of Surgeons of England is therefore a body which is fitted by experience to offer evidence to this Royal Commission on dental surgery at hospital and consultant level. Moreover, its position as the licensing body for a high proportion of the dentists in general practice leads it also to extend its concern to the conditions in which these licentiates work. The causes of dissatisfaction among them were studied in detail by the Committee on Recruitment to the Dental Profession and are subject of comment in the Report of that Committee (Paragraphs 61-74) and indeed of recommendations for a thorough review of the whole system of remuneration. The striking decline in dentists' earnings during the latter part of their careers, a circumstance which apparently obtains in no other profession, the virtual disappearance of the goodwill value of practices, and apprehension that financial returns may be abruptly diminished by sudden alterations in the regulations, these are circumstances which the College views with no less concern than did the Inter-Departmental Committee. The presentation of further evidence on these aspects will, however, come more fittingly from other professional organisations.

32. The following paragraphs, in which the number corresponds to the list of questions supplied by the Royal Commission, contain information arising out of the experience of the College in its educational activities and through its connection with hospital and consultant practice.

(ii) *The quality and quantity of newly qualified dentists*

33. When the Dentists Act of 1921 was passed there were only some five thousand Dental Surgeons in the United Kingdom and many of these were medical men with dental qualifications. From the days of John Hunter (1728-93), who incidentally practised dentistry himself, dental surgeons had regarded themselves as practising a branch of surgery and as being required to conform to the same code of professional ethics as general surgeons. There was also a strong family tradition so that recruits were often drawn from professional homes where learning and culture were honoured for their own sake. In the circumstances that obtain today, however, professional men whose incomes are just above the arbitrary level for Local Education Authority Grants often find it impossible to give a professional education to two or three children, and dentistry is the poorer by the subtraction of an element which proved so important in its historical development and which we should expect to have played a leading part in its further establishment as a free, liberal and learned profession.

34. The quality, in so far as this refers to the professional competence of the new entry, however, is safeguarded by the standard of the examinations which are required to be passed by candidates for the Licence in Dental Surgery of this College. Moreover, since the war—except for 1952 and 1953—the number of applications for places in the Dental Schools has been greater and there has therefore been an opportunity for the schools to be more selective. The academic standard of those entering the profession is thus maintained, though for the reasons we state above we could wish to have more sons and daughters of professional men; and indeed it would seem to be a very serious criticism of the conditions under which Dental Surgeons practise today that they should often be unable to afford to put their sons and daughters into their own profession. We do not believe that the Royal Commission will allow this unhappy state of affairs to escape their notice.

35. The quantity is a matter of greater concern.

36. Although there have been more applicants since the war there was a dangerous fall in 1952 and 1953 which led to the Committee on Recruitment to the Dental

Profession being set up. The warning in the Report of that Committee that the number of practitioners is about to diminish, whatever steps be taken to increase recruitment, is viewed by this College with the gravest concern and we would urge with all the emphasis at our command that the remedies proposed by that Committee be adopted without further delay. These include the building of more schools and the training of more teachers as well as securing a greater degree of contentment amongst members of the profession themselves who must always be the best advocates in attracting new recruits.

37. The dental profession makes a contribution to the comfort and efficiency of the community that is both important to its welfare and highly prized by the individual though dental services are no doubt taken very much for granted so long as they remain available. It would now appear that it is already too late to avert a shortage that may well amount to a national crisis of no small significance. It is therefore a matter of great urgency to apply the remedies prescribed. The one with which the Royal Commission is particularly concerned is that the profession should be relieved of financial anxiety and that the sense of injustice under which they labour should be removed. This can only be effected by establishing their remuneration on a scale to give them an assured social position appropriate to the responsibilities they shoulder, to the length of their training, to their arduous daily task and to the importance of the service they render to the community.

38. This is not only a matter of justice but is an essential corollary to the building of new schools if the entry is to be raised and maintained at the level recommended in the reports of both the Committee on Recruitment to the Dental Profession (1956) and the Inter-Departmental Committee on Dentistry (1946), a level which is minimal if the most serious results of the impending shortage are to be averted.

- (iv) *The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the individual grants and the proportion of students receiving them)*

39. While the length of the degree course for dentistry is in some Universities the same as that for medicine, in general the courses are somewhat shorter. Nevertheless, the cost of the training is greater. This is due in some cases to higher annual tuition fees for dental students; and in any case, books, dental instruments for use in the clinical years, anatomical specimens, mechanical tools (all of which the student is required to provide himself) together with hire of microscope cost over £200.

40. These circumstances accentuate the difficulty that professional men experience in sending even one child to the University for five years if their incomes are just above the level applied by the Local Education Authorities in awarding their grants. If they have more than one child to consider the difficulties may be insurmountable.

- (vi) *The relative advantages and disadvantages, financial and otherwise of service as:—*

- (d) a whole-time consultant,
- (e) a part-time consultant with the maximum number of sessions,
- (f) a part-time consultant with only a few sessions,
- (g) a Senior Hospital Dental Officer,
- (h) a General Dental Surgeon in the hospital service,
- (j) a dentist in any other sort of practice or employment.

General Comment on Hospital Staffing Problems

41. The number of Dental Consultant appointments, either full-time or part-time, is quite insufficient for the needs of the Hospital Service. Moreover, those who have conscientiously undergone the long course of training as Registrars, and who are worthy of consultant status, find that few posts are available to them. This inevitably leads to frustration and widespread dissatisfaction so that it has become

a matter of extreme difficulty to encourage enterprising young men of merit to train as consultants. Recruits to this branch of the Profession have been lost and will continue to be lost as long as this feeling prevails.

42. Whatever may be the reason, Boards of Governors of Teaching Hospitals and Regional Hospital Boards have not met the basic requirements of the recommendations relating to the dental service in hospitals and it would appear that the only solution is a separate central grant to promote the hospital dental service.*

43. The provision for dental treatment in general hospitals is correspondingly unsatisfactory; in many either there is no dental department or else it is inadequate in respect of accommodation, facilities and staff. Consultants may have to carry out work which is within the capacity of a general dental practitioner and which the general practitioner could do more economically. Where there is no consultant, or where adequate facilities are lacking, registrars cannot of course be trained.

(vi) (d) *a whole-time consultant*

(vi) (e) *a part-time consultant with the maximum number of sessions*

44. In whatever category he may serve, the full-time Officer is at some disadvantage in comparison with his part-time colleague in respect of allowances for taxation. Nevertheless, since private consulting practice is meagre in dentistry in comparison with that in medicine and surgery, it would seem that a large proportion of full-time or almost full-time posts is most appropriate. We regard this as a regrettable necessity and we endorse the views expressed in Part A as to the need for a special measure of independence to which a professional man is entitled and which is essential to those who have the responsibilities of leadership.

(vi) (f) *a part-time consultant with only a few sessions*

45. This is the usual type of consultant appointment now available particularly in teaching hospitals. It is a continuation of the system of honorary appointments which existed before the inception of the National Health Service. The dental consultant attended on a small number of sessions per week without remuneration, and these posts were only held by those who were sufficiently interested in hospital and teaching work to do it without payment; they formed the backbone of the voluntary hospital system.

46. In teaching hospitals there is a strong case for the continuance of part-time appointments but each should involve attendance on a minimum of 3-4 sessions per week. The holders of these posts in addition to carrying out clinical work play a most important part in undergraduate instruction.

47. At present, however, a number who attend only for one or two sessions weekly have twenty-five years to serve and it would therefore be necessary either to increase the number of consultant sessions or to wait until consultants retire and give their sessions to their colleagues. The latter procedure would block the young entry to consultant rank for a long time, and we strongly urge that in those teaching hospitals where this system finds its fullest expression the number of consultant sessions be increased.

48. Apart from the teaching hospitals, we believe that, elsewhere in the Health Service, dental consultants should be employed for one or two sessions per week only in exceptional circumstances, and the comments in Part A are endorsed. Such a system does not promote efficiency or economy in the working of the hospital service.

(vi) (g) *a Senior Hospital Dental Officer*

49. Appointment as a Senior Hospital Dental Officer was intended for those whose duties included clinical teaching or work beyond the scope of a General Hospital Dental Practitioner. It was not intended that dental surgeons in these grades should

* Section XI. Sub-section 92 Ministry of Health Publication (1950)
"The Development of Consultant Services"—*Annexure*.

take the place of consultants and we deplore that some appointments of this kind have been made where the posts carry the responsibilities and require the experience of a consultant.

(vi) (h) *a General Dental Surgeon in the Hospital Service*

50. Attention must be drawn to the disparity in sessional pay between General Medical Practitioners (at the rate of £175 plus the recent addition awarded by Parliament) and General Dental Practitioners (at the rate of £150 plus the recent addition awarded by Parliament).

51. There seems no justification for this, particularly as a General Dental Practitioner's practice expenses are much heavier than those of a General Medical Practitioner and continue when he is away from his surgery.

(vi) (j) *a dentist in any other sort of practice or employment*

52. *Research Appointments*: The College has long shown an interest in dental research which culminated in the creation of a Department of Dental Science within the College in 1955. The position of the whole-time dental research worker is considerably less advantageous financially than that of the general dental practitioner. He requires much longer training during which time he is not earning and then obtains remuneration which is much less. He has doubtful security of tenure and doubtful prospects of advancement. Facilities for work are often poor and there are few alternative posts to which he can change if dissatisfied. He does not receive tax concessions to which a dental surgeon in general dental practice is entitled.

53. *Teaching appointments*: Junior dental teaching posts are increasing in number, but do not attract a satisfactory field of applicants owing to the small salary which attaches to them. The junior whole-time dental teacher suffers financial disadvantage compared with the general practitioner of the same age as regards scale of salary and liability to taxation. This disparity is most marked at the beginning of a teaching career but an even more serious factor in dissuading able young men from embarking on one is that there are too few senior posts to which they may aspire.

54. If any expansion of the schools is to take place the recruitment of junior staff will present greater difficulties than anything else.

(vii) *Any special difficulties encountered by the Registrar grades*

55. As we have said there is much dissatisfaction amongst holders of this type of appointment, due to the dearth of senior posts in the Regional Board hospitals and also in the teaching hospitals.

56. *Senior Registrars*: These are men who hold a higher dental qualification and not infrequently a medical qualification also. In the case of the senior registrar with higher dental qualifications only, it is necessary for him to spend 2 years as a registrar and 3-4 years as a senior registrar. Taking into account his house surgeon appointments, this means that a man cannot consider his training complete until 11 years after commencement as an undergraduate student. A man holding a medical qualification may take longer still. The dental surgeon is then between 28 and 33 years of age. Having been encouraged to embark on a full-time training, on the assumption that there will be an appropriate number of full-time senior posts available in the future, most senior registrars find on completion of their training that there are no consultant posts available owing principally to the failure of the majority of the Regional Boards to develop the dental service in their hospitals. It is true that a man who has had a registrar's training of seven years could find a place in private dental practice but it would be a bitter disappointment and he would have been subjected to severe financial stringency during his training without commensurate gain.

57. As a result of this situation applications for consultant training from young dental surgeons of the right calibre have virtually ceased, and in our opinion, it is an urgent requirement that there should be a sufficient number of full-time consultant posts established in order that there may be an uninterrupted rise from

registrar to consultant status for those who have submitted to the arduous training involved and are worthy of promotion.

58. Excluding honorary appointments, in England, Wales and Scotland there are 293 dental consultants (including those in teaching hospitals) and this would at first seem to be a reasonable number in proportion to the total number of dental surgeons in these countries. However, on investigation it is found that many of them are part-time consultants and are doing only from 1-3 sessions a week. Estimated on a full-time basis, therefore, the total number of dental consultants in England, Wales and Scotland cannot possibly be in excess of 90, and even this figure gives an unduly favourable impression since most of these consultants are concentrated in the teaching hospitals leaving very few for the hospitals of the Regional Boards.

59. We have referred to the discouraging effect of these factors on the recruitment of applicants for consultant training. In contrast, in the specialty of orthodontics where a number of consultant posts have recently been created, applicants for specialist training are now coming forward in satisfactory numbers.

60. *Registrars*: Again, these are training posts, mainly full-time, but part-time in some teaching hospitals. There is the danger that the holders of such posts in general hospitals may receive inadequate training owing to the shortage of consultants in the Regions. This is a most regrettable state of affairs, and quite contrary to that envisaged when this type of post was created.

(xi) *General comments on the system of distinction awards for consultants and the method of allotting them, with any suggestions for an alternative system*

61. As far as it is possible to judge, the system of Distinction Awards is working equitably and smoothly. We know of no method less likely to cause disharmony.

(xvii) *Proposals for specific machinery or procedures to be established for dealing with future discussions of dental remuneration*

62. We consider that it is essential to the healthy development of a dental consultant service that dental and medical consultants' remuneration should be equal. We believe that this has been a most valuable factor in implementing the dental consultant service from the beginning and has encouraged a high standard of attainment based on an equally long training for dental consultants.

63. We consider that whatever machinery be adopted for medical consultants should also be used in settling disagreements that may arise in connection with dental consultants' remuneration.

Annexure

Ministry of Health publication on

THE DEVELOPMENT OF CONSULTANT SERVICES (pub. 1950)

SECTION XI, Sub-section 92

It is advisable that a dental surgeon specialising in oral surgery should be available in a large centre or for a group of smaller centres. One such consultant, working whole-time, would probably meet the needs of a population of about 300,000; he might supervise generally the work of any resident dental staff, some of whom should be consultants in training.

JAMES PATERSON ROSS,
President.

Lincoln's Inn Fields,

W.C.2.

Examination of Witnesses

SIR JAMES PATERSON ROSS—*President*

SIR HARRY PLATT

MR. HAROLD EDWARDS

SIR WILFRED FISH

SIR WILLIAM KELSEY FRY

PROFESSOR R. V. BRADLAW

on behalf of the Royal College of Surgeons of England
Called and Examined

4054. *Chairman*: Sir James, we have had your memorandum, and we have considered it carefully. We asked you to come a little bit earlier this morning than we have been asking most of the hodies because we thought we would probably be able to get through this before lunch without pressing you unduly. I do not want to restrict you in anything you may want to put either on these or other points which may have occurred since you first got our questionnaire on which you have given us these answers; but you may know that we were in Scotland a few weeks ago when we saw the three Colleges up there, including the Royal College of Surgeons of Edinburgh. In the course of our visit we asked some 600 questions, so that we have covered some of the topics in which we are particularly interested fairly thoroughly. We may not therefore need to go into all those so thoroughly with you. You probably realise, and I do not need to say, that it is our job to test all the submissions made to us by thorough questioning, and that if we do not nobody else is there to do so. We would hate it to be thought by any witness, either those present or those who have appeared before us already, that we have made up our minds on any of these particular matters about which we are questioning. Our questions are not intended to show that. You will also know that we have already sent out to doctors a questionnaire on actual earnings and it has already been answered by a very high proportion of them. A similar questionnaire has also gone out to members of some other professions and will go to a good many others, but until we get those facts we cannot possibly deal with the second part of our terms of reference, which is broadly to recommend actual levels of remuneration in the light of the current earnings situation. I wished

to make just those few preliminary remarks.

Therefore you will appreciate that any questioning that we may go in for does not imply disbelief in any points you have submitted, or scepticism. Equally whenever we miss a point you have made in your written evidence it does not mean that we have accepted any proposition put forward by you.

We have distributed the work of this Commission mainly to two sub-committees. I do not think it is because someone of your name is President at the moment that we have distributed this one to the Northern sub-committee under Sir Hugh Watson, but I think you will probably be able to talk in very similar idioms if you feel so inclined. Sir Hugh has been Chairman of the sub-committee which has considered your evidence, and I would like him to take over.

First of all I see that you are represented by six people, and I believe one of you can speak particularly for the dentists, 'is that so?'—*Sir James Paterson Ross*: Sir Wilfred Fish, Sir.

4055. To the extent that there are any special points affecting the dental profession rather than the medical one, Sir Wilfred will be able to answer?—I would like to make it clear that there are actually three representatives of the dental profession here, Sir Wilfred Fish and Sir William Kelsey Fry, and also Professor Bradlaw; so that actually there are three who can answer questions for them.

4056. *Sir Hugh Watson*: Sir James, in your memorandum which you have given to us you do outline in the opening paragraphs the functions and the status of the Royal College. Perhaps we do not need to go into that in detail,

beyond just saying for the record that the College is a scientific and educational body?—Yes, Sir.

4057. And as you mention in your paragraph 2 its activities fall into the three main beadings of examinations, research and postgraduate education. As you bring out later, the Fellowship of the Royal College is granted after some very stringent discipline and very stringent examinations, and it is in fact a highly prized distinction?—That is right.

4058. May I take it then, Sir James, that the majority of your Members, and of those whom you represent here before the Commission today, probably come within the consultant branch of the profession?—Yes, as far as the Fellows are concerned. A certain number of the Members also might be consultants, but I think, Sir, we may say that the body that we are speaking for principally are the Fellows of the College.

4059. And therefore in your memorandum on the medical side you do not to any extent deal with the problems confronting the general practitioner?—That is right, Sir. We have had them at the back of our minds because of our Members, but we have rather left that subject to others who are giving evidence to the Commission.

4060. Now, Sir James, in your memorandum, when you come on to deal with the problems which confront the Commission, the questions on remuneration, you go back to that basis with which we are all now so familiar, the report of the Spens Committee on consultants on which the consultants agreed to enter the Health Service. We have had, as you will appreciate, many opportunities of enquiring into these Spens Reports, and this one in particular. Could you tell us, generally speaking, whether the view of the Royal College is that Spens was a base on which you expected to rest for all time?—May I say one thing before that question is answered? We rather hope that you will permit us to divide the answering in giving evidence to the Commission into sections. I would be prepared to speak about the general activities of the College, and Sir Harry Platt, who has been familiar with Spens from the beginning, might, if you would permit it, answer you especially about these matters which you are asking me now.

4061. Certainly.—Is that allowed?

4062. *Chairman*: That is absolutely right. You will be asked questions by many people, and we would like you to allocate the answers to whoever is best qualified to speak.—If I might ask Sir Harry to reply to that?—*Sir Harry Platt*: I think that the first question is in a way far too sweeping. I was a member of the Spens Committee, so I am very familiar with not only its findings but the spirit and the intent behind it. What I would really like to emphasise is that the crux of the whole situation is this: the scale of remuneration the Spens Committee agreed upon as the starting point and based on 1939 values bore no relation to any of the full-time services then existing—medical officers of the Armed Forces, in Government employ, in Universities, scientific institutions, and so on. It was, as we say in our memorandum, and this is most important, a conclusion based on the equation of a hypothetical salary range with the earnings from private practice. The 4,000 odd consultants then existing—there are now 6,000—had never in their history considered that their remuneration—as with the Bar, which is the only other comparable profession today—bore any relation to existing full-time services. That is fundamental. That is the case, as it were, for the defence, that the 4,000 consultants, or 6,000 there are now, represent a body quite apart who were recruited through a totally different set of circumstances, with the highest diplomas which were not necessary in all these other services, with a long period of academic and practical training; a body which no other branch of the medical profession or any full-time medical officers in Whitehall really compared with. I would like to emphasise that.

4063. I accept that, but, of course, as you know far better than we do, before the National Health Service there were, broadly speaking—there may be many more—but there were broadly speaking two types of consultant, were there not? In the first place there were consultants in the local authority hospitals whom you probably would not regard as consultants in the sense in which you were speaking just now?—At that time very few of those occupied in the eyes of the profession, as it were, the higher brackets. It was not a question of remuneration, but of leadership and

status. It was an artificial situation created by one or two local authorities.

4064. And these gentlemen were all paid by way of salary?—Yes.

4065. On the other hand you had the branch of the profession which you really represent here today remunerated almost entirely by way of fees?—Yes, and very often with small part-time salaries either at voluntary hospitals or local authority hospitals.

4066. And in the voluntary hospitals, gentlemen who afterwards rose to the highest positions in your profession began, as you say, with a token payment and were glad to be allowed into these voluntary hospitals in order to learn their profession?—In order to practise their profession. They were not appointed to the staffs of these voluntary hospitals until they had acquired after the highest academic attainments and practical experience a degree of skill which the governing bodies of those hospitals demanded when making their selection.

4067. Before they got to that point they were in the hospitals in some capacity or another as assistants?—Yes.

4068. And they were learning their profession?—Yes, below the consultants.

4069. They were earning very little?—Very little indeed.

4070. And Spens went a long way to rectify that, did he not?—Absolutely.

4071. One of the things that the Spens Consultant Committee did was to put the embryo consultant on a much more sure financial footing in his early days than he was before.—Quite so.

4072. In paragraph 9 of your memorandum you say, Sir Harry, that it was not until 1954 that the first adjustment on the Spens recommendation was made. That is not quite so, is it?—These I think are quotations. I think my President would agree that the Royal College of Surgeons is really not concerned with half crowns, as it were. We have paid very little attention to details of remuneration. We have dealt with the broad issues in terms of the status of the consultant and with equity in the background.

4073. I quite accept that, and if you please we will not talk about half crowns. But may I ask you to look please at the first sentence of your paragraph 9 where you say:—

"The Spens Report envisaged the maintenance of the economic position of consultants and specialists in accordance with changing money values."

Spens directed that those who were to do the part of the task which he did not feel competent to carry out were to have regard to two things, did he not? To have direct regard not only to the value of money, but also to the increases which have in fact taken place in incomes, both in the medical and in other professions.—Yes.

4074. So would you agree that in endeavouring to carry out the remit with which it is entrusted this Royal Commission would be doing justice to the situation if it had direct regard to both these factors as they find them today?—Yes, Sir, provided the basic meaning of the original Spens scale of remuneration and salary scales is recognised. If I may I would quote from "The Times" the evidence from the Health Departments, and I would regard the sweeping conclusion there as quite invalid and based on the concept that doctors under the National Health Service represent a homogeneous 30,000 or 40,000, whatever it is. . . .

4075. *Chairman:* I did not catch the reference, Sir Harry. I am not quite sure what you are referring to.—I quote here: "An increase in the pay of National Health Service doctors will not only directly affect the pay of doctors in these spheres"—the spheres mentioned above, doctors in the Civil Service, the Armed Forces, local government, Universities—"but is likely to have widespread indirect repercussions throughout the salaried classes in Government and public service." I challenge that.

4076. *Professor Jewkes:* Is this from the London "Times"?—*Sir Hugh Watson:* Is it a report of the proceedings of this Royal Commission last week?—I may be out of order, but it is very germane to the thesis which the Royal College of Surgeons is maintaining in representing, as Sir James has said, the Fellows of the College who are a substantial number of the 5,000 or 6,000 consultants in the United Kingdom.

4077. *Professor Jewkes*: Could we have the date of "The Times" report. It would be useful?—I have taken the cutting without dating it. It is a few days ago.

4078. Was it in connection with the publication of the Willink Report, or anything of that kind?—It is a report of evidence given to the Royal Commission here.

4079. *Sir Hugh Watson*: Last week. It is in fact, Sir Harry, a summary of a portion of the memorandum put in by the Ministry of Health.—I would submit, of course, it is a remarkable bit of innocent or deliberate special pleading.

4080. It is undoubtedly an extract from the Health Departments' memorandum. The words are very familiar.—We challenge the very basis of this idea that the yardstick of the remuneration of the consultant, whether it is in fees, or from a system of National Health Insurance, or voluntary insurance, bears any relation to the whole-time services which have existed for generations.

4081. Could I put this question to you? Some of your colleagues are professors in Universities, and some of your colleagues are clinical professors in Universities?—Yes.

4082. Those of your colleagues who are clinical professors have the opportunity of attaining to, and no doubt many of them do attain to, the distinction awards. You must be aware that the remuneration which medical professors, clinical and otherwise, enjoy has in due course repercussions on the remuneration of other professors not only in the medical but in other faculties in the Universities?—Yes. That atmosphere of envy, shall I put it, did not exist before the war, before the Act. It was recognised that the way of life of the clinical consultant who dealt with the sick man was totally different from the way of life of someone who had entered another walk of life enjoying the remuneration, the pension, the conditions of work, and so on, of another sphere. I know there has been agitation in the Universities. I know in my own University—when this came in, I was still an active member of the Senate—that this atmosphere as it were of criticism or envy was fanned to some extent. But that is unfortunate, and it does not alter

the fundamental situation that the way of life, the arduous and continuous twenty-four hour responsibility of the man who deals with the sick patient as an individual, is a way of life which is unique, and which has no comparison in the full-time services, in the Armed Services, Whitehall, the Universities, and so on.

4083. That aspect of the matter has been pressed upon us, and rightly pressed upon us, but the fact remains that before the National Health Service you and your colleagues, if you were professors in the Universities, obtained a salary from the University, but you also derived fees from your practice outside about which the University knew nothing?—It was not their business.

4084. Nothing to do with them at all?—No.

4085. But now the position is quite different; it is known what the remuneration of clinical professors is, and it has repercussions. I would rather substitute a more colloquial word, if you do not mind, for your word "envy". Is it not part of the general game of leapfrogging which goes on today?—I quite agree with you. It is really one of the deteriorations in our society that this sort of thing is happening.

4086. Can we come back to what the Ministry of Health said last week? It does not seem to me at all unreasonable—the Commission have not had a chance of considering this among themselves—it does not seem to me at all unreasonable to suggest that the level of remuneration of consultants who now, whether they think it is a good thing or not, are to some extent at least remunerated on a salary basis, must have repercussions upon the remuneration of other medical people, and in due course on other persons in the employment of the Crown?—I think the fire has been lit, I quite agree, and those repercussions will go on now. It is a pity, but I quite agree it is a human situation.

4087. Having arrived between us at that point, may I say that this point was put up by the Ministry of Health last week as I understood it simply as a red flag, more or less by way of saying to the Commission: "You will have to be very careful what you do here, because if you do this thing in a big way it will

have effects." That is a matter which the Royal Commission will have to weigh up and decide what effect to give to it. But you see now what is meant by that quotation which you read?—I hope whoever gave that evidence had facts to support it.

4088. It was given by the senior civil servant in the Ministry of Health.—That was his personal opinion.

Sir Hugh Watson: No. I think it is fair to say that it was the considered opinion of his Department. It was their experience.

4089. *Chairman:* Sir Harry, I would like to go back a little bit further. Sir Hugh drew attention to the point in your memorandum where you seem to refer only to one of the two criteria mentioned by Spens. He said direct regard should be paid not only to changes in the value of money but to increases which had in fact taken place since 1939 in incomes both in the medical and in other professions. I was not sure whether you were challenging that conception or not?—No, Sir, in actual fact the evidence before the Spens Committee from other professions, as far as I remember, was not forthcoming.

4090. No.—It was unobtainable.

4091. Spens said, "we leave to others" the decision as to what the rate should be in 1948, or whatever year it was, but it should have regard to these two factors, and you have only named one here in your submission to us.—Yes.

4092. Does that mean that you think the second one named by Spens ought not to have been taken into account?—No, I think it represents part of a wide remit, and that part of it in practice really faded into the background. I think behind it, too, in the eyes at any rate of the medical members, was that it was a protection against any attempt to reduce the consultant's earnings by this revolutionary change into a salary system.

4093. *Sir Hugh Watson:* I quite accept the point that you made that not a great deal of information was available to the Spens Committee about the remuneration in other professions. The point that I think the Chairman has just taken up is that when they considered

the whole matter, Spens—you and your colleagues on the Spens Committee—fixed what in their opinion would be appropriate remuneration for consultants at 1939 values, and then they went in for this classic phrase with which we are so familiar: "We leave to others the problem of the necessary adjustments to present day values . . .". That was in 1946, and you remember Spens never went a day further than 1946—"We leave to others the problem of the necessary adjustments to present day values of money, but we desire to emphasise as strongly as possible that such adjustments should have direct regard not only to estimates of the change in the value of money, but to the increases which have in fact taken place since 1939 in incomes both in the medical and in other professions."—I agree that is quite impeccable.

4094. What the Spens Committee had in view at that time was that in any discussions which were to ensue in the future, and the Government have always said that their view of Spens was that the remuneration of the medical profession should be discussed with the profession—in your case in Whitley B—on the basis of these two factors, due regard being paid to both of them. As you are aware, there was not available to Spens a great deal of information about the incomes of other professions. But as the Chairman began by saying, this Commission is sending out questionnaires to I think it is 17 other professions, and we would hope to get from that fairly full information about the spread of incomes in those professions in recent years. Would you agree that that ought to give a reasonable basis of comparison?—It would be, of course, a basis of argument or discussion on equitable increases, but again I come back to this point that even the earnings in accountancy, engineering, and so on, bear no relation really to the earnings of consultants in this country. Whether there is a percentage increase on present day values, and so on, which has some reference to the financial picture which other professions give is immaterial, so to speak, from the point of view of the Royal College of Surgeons. That must be left obviously to negotiation and discussion, but we do represent a wing of the profession which in a free profession has set its own standards of remuneration.

4095. *Professor Jewkes*: When Professor Bradford Hill was making a census of pre-war earnings for the purpose of your Committee, he had to find his own definition of consultant as there was no standard definition of consultant. He did that, and he found 1,700 consultants who conformed to his definition. He proceeded to collect figures for the earnings of those consultants, and it was upon those earnings mainly that the Spens Consultant Committee made its decision. When we turn to the early days of the National Health Service we suddenly find there are 5,000 consultants.

—Professor Bradford Hill's analysis was based on a sample of those who sent in a return—a bit more than a thousand—those who gave complete returns for their net and gross earnings during the 1939 period, covering the whole range of the fields of medicine, surgery, the major specialties, radiology, and the like. It was regarded by the statisticians as a significant sample. Those were facts, those were earnings. It was evidence of the gross earnings, and the variation in overhead expenses, very high in some branches like radiology, lower in medicine, and so on. That was of the 4,000 or 3,000 odd consultants who were asked to return this information. It was a smaller number, but regarded as significant, and on that the mean income was calculated; on that was built the merit award system in order to bring earnings throughout the age periods up to the earnings which had been derived from free practice, in the free market as it were, from consulting fees.

Professor Jewkes: I am afraid I put my question very badly, Sir Harry. What I was meaning was that in fact Professor Bradford Hill took the sample from 1,700 persons whom he believed constituted virtually the whole of the group of consultants in England in 1939.

4096. *Chairman*: In fact, Sir Harry, I think he sent a form to every single person when that list was compiled. This is what he says: "All the part-time visiting staffs of local authority or voluntary hospitals".—There were many more at that time I am sure.

4097. *Professor Jewkes*: What is the explanation of the big jump in the number of consultants?—1,700 was not the number of consultants in 1939 in this country. There were many more. Since

the Act a great number of new consultant posts have been created. At the beginning of the special Merit Award Committee of which I was an original member, and remained a member until last year, the number then was probably in the whole constituency in England and Scotland something like 4,000. I am just guessing the figure, but the number has gone up considerably because consultants have been appointed now throughout the whole of the realm to the smaller centres where no consultant previously existed. These are people who have gone through this long and arduous academic and practical training which the consultant life still demands.

4098. Is it possible that when the National Health Service was instituted it did mean that a number of people who before the war would not have been regarded as consultants then entered the consultant class?—No, I do not think so.

4099. *Sir Hugh Watson*: I was rather interested to round off Professor Jewkes' point—we were told by Lord Moran the other day that there are now 6,700 consultants in England and Wales, and a number, to him unknown, in Scotland in addition.—*Mr. Harold Edwards*: May I say on this point that the term "consultant" is a new term, and we were not consultants before the war, until we retired we were consultant surgeons. I have not read Bradford Hill so I am speaking without adequate information, but I should suspect that there was some disparity caused by determining exactly what a consultant was in those days. We were honorary surgeons or honorary physicians unless we were in full-time service, and I imagine that there may be as a result of the great difficulty in defining this term some disparity in the numbers before the war when this was done, or just before the war when there was Bradford Hill's review.

4100. *Professor Jewkes*: No, in connection with the Spens Report.—Just after the war.

4101. *Chairman*: It was done after the war in relation to people known to be practising just before the war.—I recall that, but I think probably the difficulty in defining what was then a consultant, which is entirely a new term since the Act, might have been one of the reasons

at least for this difference in numbers.—*Sir Harry Platt*: I would submit that the constituency existing at the time of the Spens Report did not represent any dilution. The names were taken from the directories of the hospital staffs, both of the voluntary hospitals, teaching and non-teaching, and of the local authority hospitals, and really included men of consultant status in every sense of the word who were not practising in general practice.

4102. *Sir David Hughes Parry*: Could I put it in this form? I understood you to say that there were full-time salaried doctors on the staff of local authorities whom you would not regard as consultants, is that right?—A mere handful at the time.

4103. Have you any idea of the numbers of those who are graded now as consultants?—Most of those by virtue of long experience have received consultant status.—*Sir James Paterson Ross*: I wonder whether I might put in a word here to help on *Sir David's* point? I think we would all agree now with what *Sir Harry* has said, that before the war many of the local authority hospitals were, we would regard, under-staffed, and staffed by men who had not gone through this training, men who did not have the Fellowship of the Royal College of Surgeons, for example. And there is no doubt whatever that one of the effects of the Health Service has been to upgrade the hospitals in different parts of the country so as to give a more uniform improved service—in surgery we are talking about particularly; and it is for that reason I think, among others, that the number of consultants has increased. It is not the increase in the numbers of consultants in the great teaching hospitals, the well-established hospitals, but the improvement in the standard of the surgeons up and down the country, the increase in the facilities available to patients uniformly all over the country. I think that is one of the great changes made by the National Health Service.

4104. *Chairman*: That you would regard as a considerable advance, would you, *Sir James*?—Yes, *Sir*.—*Sir Harry Platt*: Barrow-in-Furness, which *Lord Moran* used to quote, both in Spens and in the early days of the Merit Award Committee, now has a complete range of consultants, younger men, highly

trained, appointed since the Act, and that is the great triumph.

4105. *Professor Jewkes*: I think the point I am trying to get clear is this. After all you were on the Spens Committee and you know. When you were discussing the level of consultants' earnings under the Health Service, were you thinking about 1,700 people, or were you thinking of 4,000 or 5,000?—I cannot remember the constituency at that date. It was more than 1,700. We were thinking of the whole lot who held reputable hospital appointments and who were practising as consultants in the sense that they were consulted by general practitioners.

4106. You were thinking of more people than *Dr. Bradford Hill* had taken into his census?—We regarded that as a sample, those people who took the trouble to fill up the questionnaire and return the details of their incomes.

4107. You were thinking of the numbers in the population from which *Dr. Bradford Hill* decided to take the sample?—Certainly.

4108. *Sir Hugh Watson*: We have had a great deal of evidence about the translation into modern terms of the recommendations of your committee. It has been suggested to us that the way in which to apply that double-headed recommendation of the Spens Committee is that this Commission should recommend that the medical profession should have remuneration based on the value of money or on the incomes earned by comparable professions today, whichever is the greater. What would you say to that?—That seems to me to be prejudging the whole situation, as it were; that is a plan of action which the Commission will have to consider, because I think we all appreciate the very great difficulty you are facing in this quite novel situation. But it seems to me again one of these sweeping statements. In other words, are we to take the income of *Sir John Simon*, as he then was, or *Sir Hartley Shawcross*, and so on, at the Bar, or are we to take the high salaries of the great leaders of industry and corporations whom I need not mention? But that is your job. I am not sure that the medical profession, and particularly the consultants for whom we speak, really feel that our case—and the Royal

College of Surgeons is not putting forward any extreme claims—should be judged by these other yardsticks.

4109. By the yardsticks laid down by Spens you mean?—On the spirit of the advance from that base, which was, as we said so many times, the equating of a salary with the income earned in free conditions.

4110. *Chairman:* Sir Harry, I think I have got the sense of what you are saying. How do you consider that there should be some sort of relationship established between the earnings of consultants, the average consultant if you like, and those of other branches of the profession, or do you consider that they are so far out that it is impossible to compare them?—There should be a relationship with those in other branches of the profession, in general practice, who deal with the sick man as an individual.

4111. Other branches of the profession, those in general practice on the one hand, and earlier stages in your own branch of the profession, for instance the registrar, senior registrar, senior hospital medical officer, and so forth?—During the period of training which leads up to the final act whereby a man becomes a consultant, obviously I think we would agree that the scales of remuneration during the time a man is in *status pupillari* should be related to the general economic pattern.

4112. I still do not think you have quite answered my question, and I was not quite sure you had answered all Sir Hugh's either. Are you maintaining that there should be a relationship or that there should not be a relationship between the consultants and, if you like, first of all the general practice branch of the profession?—Yes, I think it was felt in the Spens Committee, and later in the one on general practice, that there should be a lesser gap between the general practitioner, the experienced general practitioner, and the earnings of the consultant than had existed in the older days. The profession felt that as a whole.

4113. The general practice report was actually a good deal earlier, not later than the consultant one.—Yes.

4114. But I am talking about what you feel now. Do you feel there should be

a relativity or relationship between the earnings of the consultants and those in general practice?—Yes, all those who deal with the sick person as an individual who have a totally different contract in life from those who hold posts in whole-time services which have existed for generations, and who are not dealing with the sick man.

4115. *Sir Hugh Watson:* I do not follow what you mean. Who are these last people to whom you refer?—Medical officers in the Armed Forces, medical officers in the public health services—I shall probably not be popular for saying this—in Whitehall and elsewhere, for whom the highest academic qualifications are not necessary for that way of life.

4116. *Chairman:* Nobody was suggesting that any of these figures should be identical. The question is whether there should be a relationship, whether they should really have any bearing to one or the other at all?—I suppose in justice there should be some relationship in order not to create a feeling of injustice throughout the profession as a whole.

4117. *Sir David Hughes Parry:* It is not a question of envy or injustice, but a question of recruitment into different branches, is it not?—No, because the recruitment to the consultant life—and I purposely avoid the word "ladder" which my friend, Lord Moran, stumbled into—represents a series of hurdles; first of all the years of academic study and practical experience which are necessary to take the Fellowship or Membership of the Royal College of Physicians, and then the long period of hard training, and that is something quite unique.

4118. *Chairman:* Well, Sir Harry, there are now quite a lot of people who are whole-time consultants, are there not?—Yes.

4119. And the relationship as far as can be judged between the average whole-time consultant and the average general practitioner in the same sort of age does show a very considerable financial recognition of those facts as far as the whole-time consultant goes, is not that so?—I should think so. Of course, even before the war—before the Act—there were a very considerable proportion of general practitioners earning substantial incomes, and quite a number

of consultants, as Professor Bradford Hill's analysis revealed, were earning quite modest incomes. And that was not necessarily during their lean years, because that always applied; so that I do not think there has been a revolutionary change in the broad picture.

4120. *Sir Hugh Watson*: I may be wrong, but I think what the Chairman was trying to get at was a much simpler matter than I think you thought. I think the Chairman's question was really this. Do you think there ought to be a relationship between the remuneration of general practitioners and the remuneration of consultants?—Oh, yes.

Sir Hugh Watson: I think that was your question, Sir?

4121. *Chairman*: Yes. I was trying to find out to whom you thought consultants should be related?—The general practitioners undoubtedly, because that is the same kind of clinical life with a different setting.

4122. *Professor Jewkes*: We have got on to the matter of principles a bit earlier than I had expected, but since we are discussing it may I ask you about another possible principle. The statisticians tell us that the real income per head of this country has gone up by 20 per cent. in the last ten years or so. Vulgar people would just say that we have never had it so good as a community, and there are people who are talking about the possibility of doubling the standard of living in the next twenty years, and so forth. The medical profession would not want to see itself cut out of some share in the steady increase in the national prosperity, would it? If you only had your earnings adjusted to the cost of living that would be tantamount to saying: "We are cut out of the general improvement in national wealth."—No, I think it is quite reasonable, but, of course, the profession for two thousand years has set its own fees in a way irrespective of the rise in per capita income of the nation, and naturally with increasing prosperity the doctor or the consultant would adjust his fees accordingly in the conditions of a free society. I think I rather regard your question as a little bit too broad to be answered.

4123. I was only thinking that since the level of medical earnings has been fixed, as you say, for 2,000 years in a

free market, and since now other tests have to be applied, other principles have to be observed, that the one I mentioned might be one that anybody that had to make decisions at the present time should have in mind. For example, as I say, in the last ten years there has been this real increase in income per head in this country of 20 per cent., or thereabouts, and no one I think challenged the point that doctors have not had any share in that. Is that felt by the medical profession to be unfair?—I suppose that where remuneration comes from the State there is bound to be a lag in increases in remuneration. But I think you can see from my thesis that there is still a sense of uneasiness with this concept of a professional service for consultants, and the concept of the State as a whole and complete employer.

4124. *Sir David Hughes Parry*: Could I suggest another principle that may have to be taken into consideration? Would you agree in the earlier days of the consultant's career there is a much greater economic security for him than there was? Would you agree to that?—Yes. Of course with spectacular inflation the economic security which arose out of Spens is now rather a bare and austere type of security at senior registrar level as we say later on in our memorandum. There is still a lean period for the young consultant in his earlier days, before he can either acquire some consultant practice or before he can qualify for a merit award.

4125. But there is much greater security really?—Yes, unquestionably.

4126. Can I take you a stage further than that? There is from the fact that there is a guarantee of seven or eight increments of salary for consultants an element of greater security in the early days, and even perhaps in the later days of the consultants?—Yes, except we have still to recognise that the security of those in higher training now categorised as senior registrars is a security in which a time limit has been set for the period of training. And if at the end of four or five years still they have not obtained a consultant post that security in theory and in practice goes, vanishes.

4127. *Chairman*: We have heard a good deal of that problem, and we will shortly be coming to that particularly and separately.—The President will

agree the College is concerned, deeply concerned, over this problem.

4128. *Sir David Hughes Parry*: The point I was making for was this, that it might be that some discount or allowance ought to be made for that security provided it is an adequate security.—Of course, yes, if you adopt this fundamental concept of the State as the employer. This, of course, is something that would be quite reasonable in view of the training he receives. But that line of argument is very repugnant, of course, to the age-long traditions of the medical profession, and it must be so, and it would be repugnant, Sir David, to the profession of which you are so distinguished a member.

4129. *Sir Hugh Watson*: Of course I quite accept that, not being on the same basis as either you or Sir David, but at the same time you have already indicated one way in which the National Health Service has benefited this country to a great extent, and that is by spreading the consultant service right throughout the country. You agree I am sure for the Royal College that the National Health Service has come to stay, and the College will accept that they are now on a different basis from what they used to be, however much that basis may compare unfavourably in their view with what it was before the war?—Sir Hugh, I do not think any scientific outlook would agree that something that has come to stay should remain unchanged. It is surely within possibility that a considerable review, reorganisation and improvement of the fundamental structure of the National Health Service might take place in years to come, and that might result in something like a reversion to the old state of affairs, as, for example, the situation which exists in the United States, Canada, Australia, New Zealand, and so on.

4130. We are concerned here with remuneration, and perhaps that is a wide enough problem for us to deal with. Now may I take you a little bit out of turn, and go to your paragraph 25, where we asked you how you would suggest that remuneration in future should be dealt with. You do not deal with it very specifically, but you do suggest in paragraph 26 that "It should not be impossible to devise an Arbitration Council of the highest level. . . ." You

probably know that there is a general principle that it is not thought that arbitration is an appropriate way of dealing with remuneration of people in the higher salary brackets who are employed by the Crown, and we are looking around therefore for some other way. Now you probably know the British Medical Association have suggested something of the nature of the Coleraine Committee. You are familiar with that?—I am not. I do not know whether my colleagues are.

4131. *Chairman*: You know what it is. It is the Committee arising out of the adoption by the Government of the recommendations of the Priestley Commission on the remuneration of the Civil Service.—Yes, now I remember.

4132. *Sir Hugh Watson*: The Priestley Commission recommended that there should be set up a committee which would be purely advisory, and that is in fact the Coleraine Committee. The British Medical Association suggest that there should be set up a body apparently comparable to that which would have a Chairman possibly with a legal background, that it should consist of other members agreed by the Ministry on the one hand and by the profession on the other hand, and that it should base its deliberations on an index which is to be agreed. We have not had an opportunity of hearing from the British Medical Association as to what they mean by that index, whether it is to be an index based entirely on cost of living, or which of the many varieties of indices, with which Professor Jewkes is familiar, they are dealing. Would you think that some such tribunal composed of eminent people, in which both the Ministry and the profession would have confidence, working in an advisory capacity would ensure that the future remuneration of your profession can be adjusted without the difficulties which have attended it in the last ten years?—I should have thought that the sort of thing that you outline would be covered by our reference in paragraph 26 to an Arbitration Council.

4133. You see unfortunately it is an essential principle of arbitration that if you go to arbitration both sides agree to be bound by the decision of the arbiter.—I think "Arbitration Council" here probably should be in inverted commas; it is just a description of a body which is not within the Whitley machinery.

4134. *Chairman*: Arbitration in this respect does not mean arbitration?—No, it means discussion.—*Sir James Paterson Ross*: Yes, fact-finding was our idea—an advisory body.—*Sir Harry Platt*: I think Sir Hugh has put forward a very interesting and very acceptable point on review machinery.

4135. *Sir Hugh Watson*: Please do not run away with any too happy idea about this, because we have not had an opportunity of testing what the B.M.A. really have in mind about this matter. But you would feel generally that, supposing this Royal Commission were to make some recommendation which was acceptable to the profession and to the Government, one that would be continued and reviewed by a body such as the B.M.A. suggest, or some such body, that would be a reasonable way of dealing with the situation?—I should think eminently reasonable, and most acceptable. You did ask about paragraph 25. The Royal College of Surgeons did not put forward any figures because we understand that our sister College, the Royal College of Physicians, had entered that field. We are told that they have suggested a scale of increments on the present remuneration.

4136. In other words, as you said earlier, you are not talking about half crowns?—No.

4137. Like Sir David you are talking about guineas rather than half crowns.—Yes, the old fee.

Sir Hugh Watson: Now, Sir Harry, I think that deals largely with the questions on the principles of remuneration, unless you or any of your colleagues wish to add anything on these matters. I think we see how you feel about this.

4138. *Chairman*: I would like to come back to one point that Sir David raised on this question of principle. He did refer to the question of recruitment. I was not quite sure, but I rather thought that Sir Harry felt that the question of recruitment, the supply of suitable candidates, both into the profession and the question that you did not answer in your memorandum about excessive resort to one branch or another of the profession—I was not sure that Sir Harry felt that had very much to do with it.—I do not know whether Sir David

meant general recruitment to the medical profession, because my colleagues are prepared to speak on that. I also think any change in remuneration would make it less attractive. Our evidence really emphasises the importance of tradition as a stimulus to the entry into a learned profession, particularly of father to son, and so on.

4139. *Sir David Hughes Parry*: Was paragraph 16 dealing with recruitment to the whole of the profession?—Yes, we were asked one of your questions, and we answered that to the best of our ability. I think we do recognise now the competition for the type of medical student, the sons of doctors, and the ones that we mentioned here, who have formed the profession for generations. They are now subjected to a tremendous bombardment of propaganda on other ways of life, great supplements in "The Times" and "The Manchester Guardian". The son of a doctor who has seen his father working hard says: "I am going to be a Cockcroft or a Chandos; I am not going to attempt this arduous life of a doctor". I think that is a new factor which may influence the quality of our recruits.

4140. Does paragraph 16 represent the view of the Royal College on the type of person that needs to be recruited—particularly the last sentence, which is a little scathing?—Yes, intentionally so.

4141. Now I wonder if you could give figures to support that, or is it merely the result of your general impression, is it pure theory?—I think my colleague, Mr. Harold Edwards, who is engaged in undergraduate teaching, will answer that.—*Mr. Edwards*: There were two questions there, were there not, Mr. Chairman? First of all the numbers and secondly the quality. Numbers are easy to report on, and as far as my own medical school goes I have got out the figures here which are very interesting to me at least, and I hope may be to the Commission. Now in 1949 we had 625 applications to enter my medical school. In 1958 we had 397. Now we work that down to an even better figure. There were in 1949 11.3 applications for each available place, and in 1958 7.2 applications for each available place, so although these figures are for a small

section in one London medical school they do show a trend in that less students are applying to enter medicine. As regards quality there is no yardstick. One can give only impressions, and one has to exercise for oneself the thought that students are not what they were when we were students. But even allowing for that we feel that quality has deteriorated, though it is impossible to prove this—there is no proof available, there are no figures available. It is only an impression, because in medicine what are you going to compare quality with? What are your standards? Is the best doctor going to be the man who has vast human sympathies, or the boy who is top of his class and easily gets a State scholarship? What are your determining factors? It is what Sir Harry implies, it is not snobishness at all, that the social background of a doctor is so important. In his work of treating patients he has first of all a human problem, and secondly a scientific problem. Our impression is that if you take that as a yardstick which is not measurable in terms of science, but only in terms of impression, that the standards of medical students are not as good as they were. I would not say they are less industrious. I think they are more industrious, possibly a bad thing. I would not say that they are not better at examinations, they probably are. If you take the other interesting point, the number of students now who are financed by some body or other, mostly the State—you know of this, of course, but it is interesting—in our own medical school in 1938 27 per cent. of the students were financed by some body or other, and now it is 74 per cent.; and the number of financed dental students has risen even more because of the increase in places at dental schools. It means, of course, that you are selecting the boy who is extremely good at scholarship, but who is not necessarily the best boy to train for this type of profession. So I would say on the whole our impression is that there is a different standard, anyway a different type of individual who is going into medicine now than was the case before.

4142. Still you have an opportunity to select one in seven, and it may be that it is not the quality of the student but the quality of the selection that may be wrong?—That is a point which we

could debate all day, the method of selection. You first of all have to base it on scholarship, there is no other way. Perhaps you may have 250 students applying at your medical school, and you are not going to interview all those. You have to take the first 60 based on scholarships and headmasters' reports and so on; and most of us believe that the right way then is not the intelligence test and writing essays, but the interview. I defy anybody to determine when they see a boy at the age of seventeen what he is going to be like at the age of twenty-three, and yet that is the best method we have of doing it, at least we think so. So that you are quite right in that there is a selection, but we are not sure it is the right selection. And as I say, and Sir James, my President, would say exactly the same thing about it, I am sure, that we have exercised a very great deal of effort in selecting the best students.

4143. Have you any ideas as to the number of students whose fathers are in the profession?—It is a diminishing number, but I have no figures.

4144. Because there have been suggestions that those figures are going down possibly not only in this country but elsewhere as well?—There is another factor, of course, and that is that the general practitioner is outside the scale of income which enables the cost of his children's training to be supplemented by the State. So the type of individual whom we want, that of the doctor's sons who are brought up in the atmosphere of medicine, becomes less and less as the doctor is unable to send his son for six or seven years training. That is the economic reason why the standard is a different standard from what the medical student used to be.

4145. But you can recruit now from a much wider field having regard to these subventions from the State?—That is absolutely true, that you have a wider field but a wider field does not necessarily mean a better field, because you have a changing level of people who are coming in, being financed from outside and knowing they are being financed from outside. I do not say this is a bad thing that you have a wider field; it is probably a good thing, because it is a good thing, I believe—it is only a personal view—to have people in this profession from all fields but not

substantially from one group of social background which we are getting now.

4146. *Chairman*: You say you are now getting students substantially from one group?—Yes, I would have thought we are getting them. In fact, if you take their history from schools and the schools they are going to you will see there is a difference as compared with before the war.

4147. Certainly there is a difference. There is no doubt about it, but they are coming in now substantially from only one social group, are they?—May I put it this way, Sir. I am not meaning this snobbishly but the group with the lower social background which we all understand is greatly different and that social background is now occupying or now composing the greater percentage of people who try to get into medical school whereas before that was a very much smaller percentage.

4148. But you are still exercising a considerable degree of selection by tests, on merit of some kind?—Yes, Sir, but I am now not talking about the people who are selected but of people who enter and appear for selection.

4149. All the applicants?—All the 500 or 250 who appear from which we would choose 60.

4150. *Sir David Hughes Parry*: And other things being equal you would prefer the son of a medical man; you would give preference to his admission?—Certainly, in the interview. He is brought up in the atmosphere, perhaps going back to his grandfather.

4151. *Chairman*: Have you any figures about applications going further back? You just gave 1949.—I have not the applications for admission in 1939 but they would be far less in 1939 than in 1949.

4152. These views which you give seem to be paralleled all over the world and I think in the United States it has been remarked on. But you would still be getting more applicants now than before the war?—Yes, I would say more now than before the war but that is only an impression.

4153. We had figures in Scotland that bore that out very much.—It is very easy to get figures. It did not occur to me to get the number of applications.

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4154. *Mr. McIntosh*: But you feel the number of applications is falling off now according to the figures you give us. Would you be prepared to express an opinion as to how much this is affected by the prospective student's knowledge about remuneration?—I think that is an unanswerable question, Sir. I think that it must have a bearing because we all of us should have knowledge of putting children into some profession or trade; it is very largely father's choice and not the individual's choice. He has to make his choice at 17 and it would appear that one of the reasons behind this is an economic one.—*Sir Harry Platt*: If I might just say, Sir, I think this waxing and waning of entries to medical school is a much more complex problem today, as indeed it always was. Long experience in a great provincial medical school, my own in Manchester, I think illustrated that, when, during the great depression periods in the cotton trade, using that as an example, the industrialists sent their sons into the professions—accountancy and medicine—instead of keeping them in the family firm. I remember being very struck by that. Now this question of decline, I think, would lead the Commission into all sorts of bypaths. The doctor's son has to compete for a State scholarship today like the son of anybody else. I think the clientele of the London medical schools differs a little over the last forty years from that of the great provincial medical schools where we have always had a cross section of all classes and I do not think that has changed very much. But the point which I did make is that there is this tremendous competition for the able boy or girl and for those from the background which we feel medicine still needs, with this vocational sense, the sense of being set apart. It is the fascination of the engineering and nuclear age which affects our recruiting.

4155. *Sir Hugh Watson*: That, of course, is affecting the recruitment to many other professions besides medicine.—It must do.

4156. *Professor Jewkes*: One of the documents which has been put before us regarding recruitment is, of course, the report of the Willink Committee. There seem to be various ways of interpreting the conclusions of the Willink Committee but at least one way of interpreting them is that there are, in fact, sufficient doctors

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at the moment. One of the recommendations of the Willink Committee, as I understand it, is that perhaps entries to medical schools should be cut down slightly. Do you feel that the Willink Committee has got the right story here?—*Sir James Paterson Ross*: It is very hard to answer.—*Mr. Edwards*: There has been a good deal of discussion; there are many factors. I do not think you can pin down one factor. The Willink Committee might have attempted to do that.

4157. *Chairman*: Might it perhaps be true, Sir James, that in some branches of the profession, perhaps in the branch of general medicine, for instance, there might be a need for fewer doctors than look likely to come forward under the present circumstances, whereas in other branches—for instance neuro-surgery—there might be a need for more; that the conclusions of the Willink Committee are not necessarily of unanimous application throughout?—*Sir James Paterson Ross*: I think that is perfectly right, Sir. You can see from the returns, even those that are prepared by the Ministry about the vacancies in certain specialties, that there is more room in some than others. There is no question about it and I think people are often prepared to switch from one to another—if they are wise, they are—at least they have always done that in the past.

4158. You are speaking today for the surgeons. The consultants as a whole are represented rather by the Joint Consultants' Committee. I wondered whether you would find it easier to answer just from your own surgical branch?—Within surgery I think there is room in some specialties more than in others. I think that is perfectly true.

4159. *Professor Jewkes*: You know, Sir James, that was rather shot at you without notice. If the Royal College wish to make any comments subsequently upon the whole question raised by the Willink Committee I, for one, would be very grateful to have them.—We would be very happy to go into that carefully. We have already had an interest in it but I do not think we have ever discussed it together to get a considered opinion about it. There is no doubt that the tendency for certain men to feel that there are more opportunities elsewhere is something which has been brought to your

notice a great deal. I mean people emigrating when they are really pretty well trained and it is not because they are not good that they go abroad, it is because they feel there are greater opportunities. That is the same problem, is it not, this question of finding a footing in this country.

4160. *Chairman*: Such figures as we have had about emigration and immigration do not show any marked change in the position.—As I understand it, Sir, there has been a fluctuation. There was a great deal of movement away in the 'thirties and then it dropped, I think, in about 1947, some time like that, and then it is tending to rise again now. I think that is the general impression but it is hard to get reliable figures about that. Having been recently in Australia and Canada myself I was struck with the number of very good men who have recently moved from this country to Canada and Australia. In conversation with them I went into this extremely carefully. I asked them why were they not able to do these things at home, both in general practice, that is, and in surgery and the answer was they could not afford to run their practices in this way at home. I cross-questioned them very carefully about that and I came to the conclusion that what they were telling me was absolutely true.

4161. In general, Sir James, I do not think there would seem to be any great disparity between doctors as a whole and the community as a whole as regards emigration?—I do not know that.

4162. But would your impression be that at least the top doctors are finding these extra opportunities abroad more readily?—No, Sir, not necessarily, they are in all grades. I can think of several in my mind now who have gone to consultant posts in other countries, but also I am thinking of general practitioners and quite junior ones at that who just were dissatisfied with their opportunities here and have found better opportunities abroad.—*Sir Harry Platt*: I am sure that is true of general practice. When I was in South Africa last year I was quite surprised to find the number of young men, of course quite a number of consultants, but others in general practice, who had gone out since the war to South Africa where the conditions of general practice are most attractive, even

in the native reserves, very attractive indeed.

4163. *Sir Hugh Watson*: There always was, Sir Harry, was there not, what you might call a considerable export of doctors from this country to India?—Yes.

4164. Which is now closed.—*Sir James Paterson Ross*: They did not have educational facilities in India like they have now, I think that is partly the answer. They now have their own medical schools.

4165. What I meant is that one of the recognised outlets for a qualified doctor in this country was to go to the Indian Medical Service. That is now closed and to some extent possibly that gap is being filled by Canada, South Africa, and other countries.—I suppose there always will be a movement. It is a question whether it was for the same reason. Most of the people in the past went mostly for adventure and I think now to some extent it is economic. They like the conditions of life as they are in medicine in these other countries better than the conditions here; that was made perfectly clear to me. They were not people who were emotionally unstable or anything like that, they were really giving me hard facts.

4166. *Chairman*: You mention South Africa; as far as we can judge, at least we are told on figures that are a bit difficult to interpret, that South Africa is one of the countries from which there has been a good movement to this country.—*Sir Harry* mentioned South Africa. I was in Australia and Canada.

4167. It so happens that South Africa was one of those countries from which there has been a good movement to this country.—*Sir Harry Platt*: In medicine?

4168. Doctors. Does that surprise you?—You mean British graduates who had gone out there and then come back?

4169. I do not think it is possible for the statistics to be as complete or thoroughly dissected as that but South Africa happens to be one of the countries in which the net movement tends to be this way. That rather surprises you I gather?—There is, of course, we all know, a very tense political situation

there which intimidates some.—*Mr. Edwards*: May I just say one thing. Sir Hugh spoke about the Indian Medical Service. Its members were really on reflection not recruited from this part of the country. I think most of the I.M.S. came from Ireland or at least a very high percentage of them, not that that is material.

Chairman: The trouble about the statistics, Sir Harry, is that when students come here from overseas they are counted as students and when they go away, having taken their degrees, they are counted as doctors and it always looks as if more doctors go than come.

4170. *Sir Hugh Watson*: Could we pass to another topic, Sir James? I am not sure whether this is for you or for Sir Harry. You laid stress in your memorandum on the desirability of having the consultant service predominantly part-time?—*Sir James Paterson Ross*: Yes. Either of us, I think, can talk about that but again Sir Harry represents in a way the part-time consultants and perhaps I represent in a way the University members that I mentioned earlier this morning. I am quite convinced myself, although I am a University professor, of the importance of the part-time consultant in medical schools as well as in the Service as a whole.

4171. This was made quite plain to us by the Joint Consultants' Committee when they gave evidence to us some months ago. The principal point that they stressed was professional freedom?—Yes, there is freedom, but if I may speak purely from the medical school point of view for the moment, I think the part-time consultant and the part-time clinical teacher has a slightly different attitude even to his clinical work. In other words, he has to be capable of managing his patient from beginning to end and instil into his students an important attitude of independence; whereas there is no getting away from it, the academic teacher does tend to rely, to some extent, on his assistant for some details which, I think, the student should learn for himself and learn to be independent about. I hope I am making this point clear?

4172. Yes.—That is why I think that a part-timer is of tremendous importance in the teaching field. Now, in regard to practice I think it is important

from the patient's point of view that he can feel that he can get an independent opinion. As Dr. Geoffrey Evans used to put it, he can buy half an hour of a consultant's time that he knows is entirely his own because there is, after all, a great difference between a private consultation and a visit to a hospital. A consultant gives the patient the same treatment and the same attention whether it is in hospital or in his consulting room, but the patient feels that he can bully a consultant much more if he has him for half an hour in his consulting room and he gets more satisfaction from that. I think that is the important thing, for the patient to feel that if he can afford it and wishes it, he can approach his consultant and cross-question him in a way that perhaps, would not be possible in the hospital where there are a lot of other patients waiting.

4173. I am very interested that you should have said that the patient can bully a consultant in his consulting room because I was talking recently to an old friend of mine in Liverpool, a doctor, and asking him what his reaction was to the National Health Service; and he felt he was being bullied by his patients. —A practitioner, I think, often feels that, because the patient has the feeling that he has made a contribution and therefore the doctor should be at his beck and call at any time. But I think that is a question of sending for the doctor and the doctor sometimes feeling that he is being sent for unnecessarily. I do not think it applies to consultants in the same way.

4174. I see. Sir James, in your paragraph 13 you deal with one aspect of the difference in the way in which full-time consultants and part-time consultants are treated by the Health Service in the way of their remuneration and so on. You point out that if the surgeon is to keep abreast of advancing knowledge he needs leisure to read, to write, and to travel. He must, therefore, be able to look forward to a standard of professional earnings which allows him to incur such expenditure without sacrificing essential family needs. What point are you exactly making in that paragraph?—He has got to have a certain level of income coming to him which enables him to indulge in these things. He must not be so taken up with routine work that he has no time

to read and study for himself. He must be able to visit other clinics more certainly than a practitioner who is not a consultant. Also, I think, we do mention here the question of entertaining his friends from abroad who come because they are making essential contacts and it is absolutely necessary that that should be so too. I think that should come under what we might call: "professional expenses" for which we think an allowance should be made.—*Sir Harry Platt*: If I might take over there, I go back a longer span of years than my colleagues, just immediately before the first world war, and it was after the first world war that the travelling of consultants became a habit. Indeed, we have now arrived at a stage when it is an obligation. At one time, as those of us well know who go back a bit, the cost of foreign travel in the '20's and '30's was comparatively small but today those things are exceedingly expensive—travel, the fares and staying in hotels, and so forth. The big income earners in the free market in the old days felt the cost of travel very little. I do not put myself in that category but I must have spent over my forty years a lot of money in foreign travel, five trips to America, innumerable continental visits and so on. It was well worth it. Now it is very necessary that that goes on. There are congresses, there are visits of small surgical colleges to bigger colleges, special centres on the continent and in the United States. It is the life's blood of the consultant's life and it is now exceedingly costly and represents quite an item out of the part-time consultant's income or full-time university consultant's income which many shrink from because it is an expense on top of their basic family needs.—*Sir James Paterson Ross*: Of course in industry, as you know quite well, better than I, all these things come under expense accounts and I think that is how people manage to do their necessary travelling because it is so expensive.

4175. Sir James, the Commission are fully conscious of the point which you and Sir Harry make, that it is nothing like so easy now for medical men to go abroad as it used to be because of the expense of travel and hotel accommodation. But there are societies and bodies and funds available which provide grants for some of these things, are there not?

—*Sir Harry Platt*: Yes, for a few individuals; there are endowment funds of the great teaching hospitals here and there and actually a certain amount is allowed in the budgets of the Regional Hospital Boards and the Boards of Governors. But it is very little and it very rarely covers the complete expenditure now incurred: it is, I think, part of the modern inflation. I, myself, had part of my post-graduate surgical training as a young man before the first world war in Boston at the expense of my father who could very well afford it in those days; but the cost of living was then really infinitesimal. Today it is formidable to do that sort of thing and there are not Fellowship and endowment grants galore for all those who have to go to international and national congresses.—*Sir James Paterson Ross*: I think I could put it in a nutshell that for the young man training to be a consultant who is going for a year abroad there are these Fellowships and grants.

4176. Yes.—There are in the Health Service, as Sir Harry has said, certain funds—limited funds but still very important and welcome for members on study leave with pay and expenses. But these are not applicable, with certain rare exceptions, to consultants. The only exceptional ones I can think of are in the Universities: sometimes a person who goes to give a course of lectures or is going for a specific reason to another University centre to acquire a technique or to learn something, there is such a grant. But you may just say in general terms that these things apply only to the young man and do not apply to consultants as a whole; they have to pay their own expenses.

4177. *Chairman*: Have you any idea of the size of the grants that the Regional Hospital Boards have at their disposal for this kind of purpose?—*Sir Harry Platt*: Just speaking from memory the Manchester Regional Hospital Board has something like £1,200 a year or £1,500. It has to be set aside out of the budget allocated by the Treasury.

4178. How otherwise would you suggest it should be done, Sir Harry?—The difficulty is to separate the young men who are in *statu pupillari* and those at the height of their activity.

4179. I was wondering how else you might suggest it should be done if it was not to be provided for by the Regional Boards in their budgets?—It should be done for the full-timer if in receipt of a substantial income by being a non-taxable expenditure, quite plainly. Then I think it could be found.

4180. *Professor Jewkes*: You are stressing this point in connection with the whole-time consultant rather than the part-time consultant?—Yes, I may be in a minority about the part-time consultant. I think if he is in receipt at the height of his career of a substantial hospital salary and good merit award and is able to increase that by private practice he should pay for this, as we all have done in the last thirty years, out of his own pocket; but it should be a non-taxable part of his expenses.

4181. Which it would normally be at the moment?—Not admitted always or not admitted in toto. It is argued with great zeal by minor functionaries as to whether a part of it is tourism, part of it the improvement of a man's capacity to practise in the future. It is, in other words, a capital improvement. These are childish and ridiculous obstacles.

4182. *Chairman*: Is it only the whole-timers who get an allowance from the Regional Hospital Boards, Sir Harry?—No. A part-time consultant may get a grant in aid if he has to go to read a paper, say, at a congress in the United States. If it is considered it is good for the regional hospital service, he may get a small grant in aid.

4183. And if somebody is sent and gets a grant in aid from the Regional Hospital Board to travel to one of these congresses, is it taxed?—No.

4184. Well then, surely you are saying it should not be taxed when in fact it is not.—No, Sir Harry, this is a small grant out of a very limited sum of money made available by a Regional Board which may have hundreds of consultants.

4185. What you are saying really is that this sum ought to be larger, that there should be more travel allowed and paid for by the Regional Boards for consultants who from time to time

should go and represent the country, improve their mind and so forth?—Ideally the subsidy should be to those who otherwise find hardship, either whole-timers or part-timers; I think it is a question of the individual. My own feeling is that a very prosperous consultant—and there are such—should be prepared to find at any rate a greater part of this out of his earnings, being non-taxable, but that is my own personal view.—*Mr. Edwards*: Both from Regional Boards and from Boards of Governors in teaching hospitals there is always a contribution towards expenses but there is usually a very considerable expense over and above this contribution which is not taxed. What Sir Harry is saying is that that amount over and above what you have to pay out of your own pocket should be exempt from tax. That is not the case in full-time posts and it is not always the case for the part-timers that they can be exempt.

4186. *Professor Jewkes*: So if a whole-time consultant goes to a foreign conference it is at his own expense; there is no question at all of his being allowed that as non-taxable expense?—That is so.

4187. And that is the difference between the whole-timer and the part-timer?—That is the difference, but at the same time it is not always possible even for the part-timer to get exemption because of minor functionaries, as they say.

4188. Whilst we are on the question of whole-time and part-time, Sir James, is it your opinion that there is a right sort of balance between the number of whole-timers and the number of part-timers? Could a hospital run properly if there were no whole-timers or no part-timers?—*Sir James Paterson Ross*: A teaching hospital, you mean?

4189. Both types.—Yes. There is no denying that before there were whole-time professorial units in teaching hospitals the hospitals got on very well. But we do not think the scientific side of surgery and the advance of the subject was pursued quite as well as it should be. The treatment of the patients was very satisfactory but the advancement was not taking place as it should. There was a great deal of comparison between this

country and America and so on. That balance has, to a great extent, I think, been put right by the introduction of whole-time professorial units in a large number of teaching hospitals in this country. I think that the proportion at present existing in many of the schools—not all of the schools, because in many of the schools in London do not have professorial units—but in those that have, I think the proportion is about one whole-time unit to three part-time units. It is probably about the right proportion. In regard to the Regional Board hospitals I do not know that I am really in a position to state how many whole-timers there should be in that service and I would really like Sir Harry, who is very familiar with the Regional Board service, to say about what the proportion of whole-time staff to part-timers in those hospitals should be.—*Sir Harry Platt*: I do not think that one can answer that question and I cannot even remember the figures from my own Regional Board which were published only the other day. In the Manchester Regional Board, of which I am still a member and have been since the very beginning, we have in the new consultant appointments since the Act tended to appoint some of the younger men for a period of three years, until they can settle down, on a full-time contract with the right at the end of three years to ask the Board to put them on maximum part-time; and that has worked very well. It has given them three years to settle down without undue economic strain and when they have established their position they go on to maximum part-time where they are now permitted to do domiciliary consultations and to devote a very limited part of the week to such strictly private practice as may come their way. Without any arithmetical formula we found that a very useful working scheme.

4190. *Chairman*: It fits in on the whole with the needs of the particular hospitals in the service?—Absolutely, but there are certain fields where expensive apparatus and so on is involved, as in radiology where many of the appointments have been deliberately, at the request of the consultant, made on a full-time basis.

4191. *Professor Jewkes*: You would let the distribution settle itself?—Yes, it just finds its own level.

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4192. *Sir David Hughes Parry*: But in certain hospitals you may require a full-time person to go on as such after the three years?—That is really the pact, as it were, with the young consultant at the time of his appointment. It is our practice in our region to give him the assurance that after a certain period he will have the right to ask to go part-time. And it comes back to the majority feeling in the profession, no doubt voiced by the Joint Consultants' Committee, which is reinforced by this Royal College and I think, probably our sister College—I do not know—that the consultants of the country are whole-heartedly in favour of a predominantly part-time relationship with the so-called employing authority.

4193. I notice that the word you used is "predominantly". There must be parts of the service that require full-time consultants apart from this younger generation doing their first three years?—*Sir David*, if you ask me as an individual whether this service would run at a high level on an entirely part-time basis, my answer would be, yes.—*Sir James Paterson Ross*: May I make a suggestion, Sir? I do not know whether *Sir Harry Platt* will accept it, but one answer to *Sir Hugh's* question whether some of the people might remain in whole-time service in the Regional Board hospitals is, I think, probably that most of them who do so are there in an administrative capacity for part of their time. In other words, they are essentially remaining on the clinical side but instead of using the rest of their time for private practice they are using that time for the administrative duties of the hospital. Is that not so?—*Sir Harry Platt*: In the mental health service, that is, of course, common practice. Most of the so-called medical superintendents who are also consultants are full-time but the visiting psychiatrists are predominantly or almost exclusively part-time.

4194. *Chairman*: I wonder whether you can give us a definition for which we have asked before from time to time—what is a consultant? What is a consultant's work? We have so often heard it suggested that consultant work is being done by other people without those people being recognised as consultants.—I think it could be answered if you want a definition, quite simply. The essence of a consultant is, first of

all, that he is consulted by other members of the profession and patients are referred to him. He is completely and absolutely responsible for that patient's care. That distinguishes the consultant from anyone else who is in *statu pupillari*. The senior registrars, many of them men of considerable experience, doing major surgery, carrying out responsible work in fields of medicine and obstetrics and so on, are not in the final analysis responsible for that patient. They have a delegated function. The consultant has the undivided responsibility for the care of a patient. The general practitioner, of course, has the same.—*Sir James Paterson Ross*: I think when we say that the registrar is doing consultant duty what we really mean is that, in fact, this responsibility of the consultant is honoured more in the breach than in the execution of the thing. In other words, the registrar is being made responsible although he is not or should not, in fact, be responsible for a patient.

4195. *Sir Hugh Watson*: So that really, *Sir James*, while in point of fact, to use *Sir Harry's* expression, the registrar is in theory in *statu pupillari*, by the time he has been a senior registrar, as we are told, for 3, 4, 5 or more years he is himself, although not in name, in quality, very nearly of consultant status?—Yes, Sir. The idea of the senior registrar is that he is in training for a consultant post and so long as there are consultant vacancies he is an applicant for them—it is a matter of supply and demand, as you know, at the present time—and if successful he changes his status but does not change his capability. But he is in charge as a consultant and the natural evolution should be from senior registrar after the fourth year into a consultant grade.—*Sir Harry Platt*: So it is really quite simple. Whatever he does they are not his patients. They are the patients of the consultant who is his chief.—*Mr. Edwards*: And, of course, he only undertakes care of patients at the direction of his chief. If I may I would just like to underline the first part of *Sir Harry's* definition of consultants. It is derived from consultation with the doctor and not with the patient and so consulting practice is always in association with the patient's own doctor, both in hospital where the only patients

you see are those who are provided with doctors' letters and in the patient's home. That is the real definition of consultant, I think, but, of course, what Sir James and Sir Harry say in relation to senior registrars is absolutely right. They are delegated and one only allows one's assistants to do certain operations when you feel they are entirely competent to do those operations and even then it is only under direction.

4196. Thank you, Mr. Edwards. You have made that very clear. I have always understood this is rather comparable to the relationship which exists in another profession—a client, his solicitor and counsel. Is that more or less a reasonable comparison?—I have always understood so.—*Sir Harry Platt*: I think the Bar is probably a little more rigid because there are occasions when patients do seek access to a consultant without their doctor.

4197. But by and large. In your paragraph 18 you point out the present unfortunate position with regard to senior registrars and you say there is a moral obligation to ensure their future. We have had this problem put to us by many people and many suggestions have been made. What is the solution of the Royal College to this problem?—*Mr. Edwards*: I think what we are most anxious to do, Sir, is to underline that there is a very big problem here rather than at this moment to suggest any solution to it. I am afraid that is not being very helpful but there is, as we have tried to show, a moral obligation to employ these highly trained men. The obligation particularly refers to those who were given Government grants at the end of the war in order to enable them to become consultants. To the younger people perhaps this obligation does not apply quite so much. But to any one of us—and we all have from time to time to sit as assessors—it is always a most depressing experience: I have just this last week done this thing. The man who got the job, which was a very attractive job, was aged 43; the youngest applicant was 34. There were 26 of them and they were all fully trained surgeons, most of them had their Master-ship of Surgery. That is the situation we are facing all the time and it is a problem which we regard as being very much overdue for solution, one which

we want to emphasise, one which we want to play our part in pressing at all events. As to the solution of this problem I think there is already some suggestion which has been made: I think Sir James might mention something about that.—*Sir James Paterson Ross*: I think you know that a suggestion has been made that there should be a thorough investigation, perhaps by a working party from the Ministry and from the profession, to look into this problem to try to see exactly the size of it and what the right solution should be for these young men. There is no question, as Mr. Edwards has said, that all of the senior registrars who are time expired are capable of becoming consultants but there are not posts for them. The question at once arises whether more consultant posts should be made so that this anomaly of senior registrars acting as consultants is not perpetuated. But that, of course, is a matter of whether it can be afforded and so on. So in a way we would prefer not to say what we think is the solution of this because it would be pre-judging the solution as far as the working party is concerned, supposing that working party was formed and had to make a pronouncement. On the other hand I think we would like to make it quite clear that we do not think they should go on as senior registrars; we think they should be given security which they have not got at the present time and that they deserve recognition for what they are in fact, that is, consultants.

I wonder, Sir, whether this particular point has ever been made to you by anybody else. A reference has been made by Mr. Edwards to the early days when so many of these men were given grants to complete their higher education because it was assumed that when the Health Service was established there would be a need for more consultants. That was all very carefully worked out before the Service started and it was on these figures that the training of these men was worked out. But what was neglected or perhaps unknown at that time was the retirement rate of consultants in the National Health Service. It was assumed that they would go on as they had before in the voluntary hospitals: men retired at 60, or sometimes after a given number of years on the

senior staff of their hospital, and the tendency was for them to go about 60 or just over. But, of course, as you know, Sir, the retiring age of the National Health Service became 65 and therefore many of these young men who had expected to get their promotion at the age of 31 or 32 found themselves 37 before they were getting it and that made this great pool of senior registrars. That is why we feel responsible for them because they were, in other words, encouraged to do this thing. In the ordinary way people entering a profession rather look to see whether there is going to be work for them before they undertake a period of training but these men were rather encouraged to do this because it looked to them as though there was going to be work for them afterwards.

4198. *Chairman*: There was actually a calculation about the establishment that was needed to fill the Service in the future and the number of senior registrars bore some relation to that calculation?—Initially, Sir, it did. Is that your question?

4199. Yes.—It was worked out, I think by P.E.P. originally in conjunction with the National Health Service, that was in the latter days of the war. I remember very vividly the whole thing was being worked out at that time.—*Sir Harry Platt*: On the other hand, I think it is true that for those who had given long war service there was the opportunity for a subsidised period of higher training and no limits were set. Is it not also true that the Minister has in the last day or two, recognised that there is a moral obligation to ensure their future by advising Boards of Governors and Regional Hospital Boards now to perpetuate the appointment of senior registrars of great seniority? He has also said it is contemplated that there will be increment on their remuneration.—*Sir James Patterson Ross*: I hope, Sir, that what I said just now will not be misinterpreted. I said I do not think they ought to go on as senior registrars. I think their appointments should continue as senior registrars until something is decided about them. But what I meant is this, it is unjust they should go on until the end of the chapter, until they retire from practice, as senior registrars.

4200. I think, Sir James, it has been put to us by others in your branch of the profession that you are really anxious that there should be a competitive entry to consultancy?—Yes.

4201. That it should not be automatic.—No, Sir. That is important, otherwise if you appoint a senior registrar you are really appointing a consultant. It must be competitive. The worst objection is that this pool has arisen in that way because it was caused ten years ago.

4202. Yes, I think we understand that. *Sir Harry Platt*, you used several times the words "in statu pupillari". Does that apply to senior registrars?—*Sir Harry Platt*: Yes.

4203. We have not had that particular definition of these training grades before but you would apply it right up to the time they become consultants?—Yes, they are undertaking higher training under the direction of a consultant. They have no ultimate responsibility for patients they treat, that is a delegated responsibility, as Mr. Edwards has said.—*Mr. Edwards*: May I add one thing, Sir, and that is I do hope that the Commission recognises that a trained senior registrar is unemployable except as a surgeon. He has no alternative. He will not be accepted in general practice as an alternative. That is very important. A second thing about which I would like to make a point is this term "registrar" is very much misunderstood generally. A registrar to us before the Health Act was a man who was in training. Unfortunately, in my view, there are now two grades of registrar—a registrar and a senior registrar. But a registrar is still a man whom you are training; it may take nine or ten years to become a consultant. I think we have expressed our views in our memorandum on that but the unfortunate thing is this: that if a man applies for a registrar's job there is now an implication already that he is in the consultant rank, as it were, which is, we find, an awkward situation. Many of us would like to see a return to the term "registrar", that is a man whom you have selected out of a number for training instead of having these two grades.

4204. *Professor Jewkes*: The Ministry of Health have given us a lot of statistics showing that the number of

registrars in the hospital service has increased by, I think, 68 per cent., between 1949 and 1956—a larger increase than in any other branch of the hospital staff. Now we know that the appointment as registrar is a short period appointment and you have told us in your report that it is becoming increasingly difficult for registrars to get back into general practice. Taking those facts together to an outsider the position seems to be rather alarming, that you are going to have a problem of frustrated registrars and surplus registrars just as you have one now over senior registrars. I wonder whether this would not give the same cause for alarm?—That is my point. One of the reasons there appear to be so many people in training for consultants is that in the old days there used to be resident surgical officers, resident medical officers, and other names given to these people. But if you call them now "registrar" they become frustrated because they have the impression they are selected to become consultants. We would like a return to some of the grades, resident surgical officer, resident medical officer and so on which they still keep in some hospitals.—*Sir Harry Platt*: From whom the general practitioner was recruited. A few after getting their Fellowship or M.R.C.P. passed on to the present-day senior registrars but even in the old days they could go into general practice in a partnership with these higher diplomas, not with the length of training our modern M.R.C.P. has, and fulfil useful functions. We make that point as one of the avenues closed in this country now is the general practitioner surgeon who is no longer functioning in the smaller hospitals. We do not, as a College, believe we could go back to the old arrangement whereby he was able, unsupervised so to speak, to practise major surgery, but we do believe he might have a place within the surgical team.

4205. As I understand your suggestion it is that there should be more flexibility in the movement between general practice and the hospital in both directions?—Unquestionably.

4206. We are only concerned with remuneration. Have you any suggestions as to how the levels of remuneration could be changed in order to break down what you suggest, as I

understand it, is the growing rigidity between hospital and general practice?

—*Mr. Edwards*: It is very difficult to answer that question because the thing is all so bound together. If you are talking about improvements in the Health Service we believe that one of them would be this greater flexibility and interchange between general practitioners and hospitals.

4207. *Sir Hugh Watson*: Can I ask you, Mr. Edwards, whose problem is that?—I think the problem is partly a medical one, partly an administrative one, and it must be bound up with remuneration.

4208. Is it an administrative one? Because some of your colleagues have fairly frankly admitted to us that the problem is really one for the medical profession themselves.—*Sir Harry Platt*: It would be in part, Sir Hugh, because we are talking now of the admission to general practice of these young men who have had considerable hospital experience which is or should be of great value.

4209. And vice versa?—He can only get in through selection by the Executive Councils.

4210. But there was also a suggestion that the traffic the other way is also difficult—from general practice into the hospital service.—Very. That, of course, must inevitably be increasingly difficult for those who have not, before going into general practice, acquired the higher diplomas.

4211. *Professor Jewkes*: Ought there to be an arrangement that they should more frequently acquire the higher diplomas for this purpose?—It is a very formidable thing for a man to get the M.R.C.P. and Fellowship. It is two examinations. You are dealing with an honours school.

4212. *Chairman*: More formidable than it used to be?—I think a little. It was always very formidable.—*Mr. Edwards*: I think that the difficulty in bringing general practitioners into hospital clinics can only be appreciated by attending hospital clinics and seeing the problems there, especially in surgery. It is a thing which we should like to do very much if it was only technically possible. But we should certainly feel

that the general practitioner who has had an adequate surgical experience to entitle him to do intermediate and minor operations should be able to do those, as he used to do before the Act. We feel there is a great gap there which could be filled, not to the same extent because, as we know, surgery that should not be done was being done.

4213. It is really primarily a problem for the profession?—I should have thought primarily it was.

4214. *Sir David Hughes Parry*: It is a twofold problem: bringing people in who have been general practitioners to be consultants and getting those who perhaps started with a view to being consultants into general practice. It is not one way.—Not entirely one way. In fact most hospitals have general practitioners, keen young men who do attend clinics, but it is a little more difficult in surgery, I would say, than in medicine.—*Sir Harry Platt*: I think, Sir, we have to recognise that the way back from general practice to the life of a consultant today is blocked really by the economic factor. Those men who came out of general practice very often lived on their savings whilst they were reading for these higher diplomas. Very creditable it was, and sometimes it took a long time—many efforts to get the M.R.C.P. or the two examinations of Fellowship. It would seem to me today economically impossible.

4215. *Professor Jewkes*: What about movement the other way, Sir Harry, from the hospitals to general practice which you suggest is even more difficult? Can that be eased in any way?—Yes, by education of the profession, by the general practitioner being ready to receive the man who has stayed longer in hospital resident posts than the average and the improvement obviously of the general practice of the future—improved conditions for a more scientific life and access to diagnostic aids, and group practice. Surely the new College of General Practitioners will be giving you evidence on the future of general practice. An increased academic standard of general practice which, I think, we all feel we want, would be a great contribution to this country.

4216. We have this extraordinary increase in the number of registrars as

shown in the figures—68 per cent. since 1949. Does this mean that registrars are doing different sorts of work than the work which they used to do? How has this increase arisen?—It is quite easy. I think I can speak from personal experience of staffing matters in teaching hospitals on the eve of war and as it was before I left the staff in 1952. There are greatly swollen establishments. There are far more in the teaching hospitals of these young pairs of hands; they have more time off. The house surgeons have weekends off and time off duty which for my colleagues in our young days did not exist at all. We had to do all sorts of work in addition, e.g. giving anaesthetics for emergencies. That does not happen today. That is one very simple explanation of the great increase in the establishment. An increase in establishment has not taken place in the non-teaching hospitals in the smaller centres. They have difficulty in getting even the numbers they had before the Act and often before the war. It is only by the existence in this country of a great many post-graduates from the Commonwealth, from India, Pakistan, that these hospitals can find these junior pairs of hands of registrars, or senior registrars. The teaching hospitals certainly have many of them, a much bigger establishment of junior people.—*Sir James Paterson Ross*: May I add another point. We gave Professor Jewkes to understand that part of the difficulty is in regard to nomenclature that Mr. Harold Edwards mentioned. As he pointed out, the people that are now called surgical registrars and certainly junior registrars used to be called senior house surgeons or resident surgical officers; in other words they were not called registrars in the past. Therefore a mere change of nomenclature has made a lot of difference and we would like to make it quite clear to the Commission that what we call junior registrars and middle grade registrars do not have difficulty in getting into outside work. It is when they become senior registrars it becomes hard and the longer they remain senior registrars so it becomes harder for them.

4217. I happen to have the figures in front of me, Sir James. These are Ministry of Health calculations. The registrars have gone up by 68.3 per cent.

As a sort of standard one might mention consultants have gone up by 29 per cent.; registrars have gone up by 68 per cent. What are called *béte* junior hospital medical officers and junior hospital dental officers have gone up by 47 per cent. and what are called senior house officers have gone up by 148 per cent. You see the point I am trying to get clear? Is there a danger that by increasing the number of young men in this section in the hospital staffing, particularly if it becomes more difficult to move from a hospital into general practice, a lot of these young men are going to be left out on a limb? Perhaps it may not be appearing now but it may do in the future?—The vast majority of these you have mentioned just now can move perfectly well into general practice.

4218. Into general practice?—Yes. I think these figures ought to be much more carefully translated into the old nomenclature when they were all termed registrar, about whom we are largely concerned.—*Mr. Edwards*: Also it is the fact if you do not know where to put a man you make him a registrar or senior registrar whereas otherwise he would have had a different appointment. I think it is important to stress the fact that the amount of surgery and medicine going on in hospitals has vastly increased over 24 years. Surgery of the heart, for example, was unknown 10 years ago.

4219. Of course surgery has vastly increased but that has not taken effect on the increase of consultants who have only gone up by 29 per cent. You are telling us younger men can, in fact, find a way out into general practice?—The younger ones.

4220. From registrar downwards?—It is not very difficult up to the second year of senior registrar. But beyond that it is extremely difficult. It becomes difficult once they are senior registrars but when they are just ordinary registrars or junior registrars and junior hospital medical officers they can quite well go into general practice.

4221. *Sir Hugh Watson*: We have been given rather the other impression. We have very definitely been given the impression that particularly if young men have specialised in matters which do not commend themselves to the general practitioner it is very difficult indeed for

them to get into general practice for which, as you know, the competition is very severe.—Yes, that is true, but *Sir Harry* was saying there is going to be a change of attitude to that. I think that part of the trouble is a natural one that they are afraid that a young man who has perhaps failed in his original ambition may be rather a sour character. It is not the training so much as his attitude to life about which they are worried.

4222. *Sir Harry* mentioned earlier on that these men are regarded as in *statu pupillari* until they reach the consultant grade.—*Mr. Edwards*: Up to the point, I think, of taking higher degrees, if a man has his Fellowship or M.R.C.S. or M.R.C.P. which he has to have before he can be accepted as senior registrar. When he gets those diplomas I think he is looked upon with a little bit of suspicion when he attempts to go into general practice. I should have thought it was time it stopped.

4223. He has burnt his boats?—Yes.—*Sir Harry Platt*: I think it is probably a little easier in medicine. There are many M.R.C.P.s in general practice but now it is increasingly difficult for a Fellow of the Royal College of Surgeons. But, *Professor Jewkes*, there is one point in the arithmetical problem which is, of course, the nomenclature. You quoted J.H.M.O.s. That grade is only used now in the mental health service. It is all very confusing, that although the consultants have not gone up by astronomical figures the figures of registrars appear to have done so. Surgery and medicine, diagnostic and operative surgery has become more elaborate and more complex; investigations take longer and employ a greater number of junior people collecting the necessary data: that, I am sure, is an important factor.

4224. *Professor Jewkes*: I understand that perfectly and that means for these young people there is a smaller chance than formerly that they will become consultants. There are a proportion of them who have to move out at some stage?—Undoubtedly.

4225. And anything we could do in the way of reviewing remuneration to facilitate that transfer you would think would be important?—*Mr. Edwards*: Might I say it is employment rather than

remuneration because if you give them remuneration you give them financial stability but not geographical stability. If they are still senior registrars waiting one day with their families thinking that they may have to apply here, then this problem is not really remuneration but employment for them; they are completely trained and able to be consultants. I think that is the problem.

4226. What I am really wondering is when you have solved your senior registrar problem are you then going to have an increased problem transferred to registrars?—*Sir Harry Platt*: You will require a lot of information of the actual potential vacancies in general practice on this. Is general practice saturated in various ways? Can a man get in at all? That is the thing, I think, you need.—*Sir James Paterson Ross*: That is why we hesitated to answer your question about the Willink Report. We do not really know that.—*Sir Harry Platt*: We do not.

4227. When we talked to the general practitioners they said it should be much easier to go from general practice to the hospital. When we talk to you you say it should be much easier to get from hospital into general practice.—I do not know that we gave the impression that there should be a barrier for the ambitious man in general practice to get out of it into the hospital field.

4228. *Sir David Hughes Parry*: You emphasised the difficulties.—The difficulties are very formidable.

4229. *Professor Jewkes*: They are technical?—Economical and technical.

4230. *Sir David Hughes Parry*: But when we talked to the other side they mentioned the difficulties in the other direction. *Professor Jewkes*: Economically and technically.—We recognise this impasse.

4231. *Sir Hugh Watson*: May we now turn to the question of merit awards with which Sir Harry is very familiar?—You have had a lot of evidence about it. As you know, it was a device to create the same range of remuneration throughout the age periods of consulting life that had been revealed to us. It was an ingenious idea of Sir Will Spens himself during one of the meetings and

those of us who have had something to do with it feel that it has worked very well. There might be other systems if there had been time to devise a totally different framework but there it is: I can only say that so far it seems to be an equitable arrangement and it has worked reasonably well.

4232. *Chairman*: Do you prefer secrecy or not?—It depends what you mean by secrecy. In actual fact anyone who is a member of a Board of Governors or Regional Board knows that the original names were passed round the table. I well remember the first list which appeared at a committee of which I was chairman; I asked the members to forget about names as quickly as possible. That has been very honourably practised throughout by Boards. People forget about them. They are not entirely secret but they are not published in the journals, they are not published in any list.

4233. *Sir Hugh Watson*: And the general practitioners do not know about them, Sir Harry?—They know nothing at all about it as far as I know. I have never heard they were interested in it.—*Mr. Edwards*: I think it is tremendously important to keep these things as secret as possible, not to protect those who have got merit awards, but to protect those who have not got merit awards because it is a most invidious situation if you have a senior man in a hospital who has not got a merit award and it is known to his junior or other people that he has not got a merit award but his junior has. For that reason, and I think it is a conclusive reason, I believe it must be secret. It must be known to all the Governors.

4234. *Chairman*: Does that situation often arise?—Not infrequently by any means.

4235. *Sir David Hughes Parry*: I notice that Sir Harry did emphasise that it was not so much a merit award as a method of remuneration. That was the emphasis?—*Sir Harry Platt*: Yes, it was a method of creating a pattern, a salary pattern based on distinction or merit. It was assumed that a man who earned big fees as a consultant had something about him which was distinguished or meritorious just as at the Bar. It may be that that does not always work out, as you know, Sir David, but there it is.

4236. *Chairman*: Has the College any suggestions as to how the system should be extended to embrace those engaged in general practice? We have all been devoting a lot of thought to that.

Sir James Paterson Ross: We were quite convinced it would be a good thing to do it but we are rather hoping the College of General Practitioners might think out the method and we rather left it to them. We have not actually given a lot of thought to it. We know ourselves there are some general practitioners who are more distinguished than others. We feel they should be rewarded for that because there is no other way of rewarding them but we think it should be done by the general practitioners.

4237. Does that mean that you do not think that the pure system of number of patients on lists is a good way of awarding merit?—I am quite sure it is not a good way.

4238. *Sir Hugh Watson*: I do not think I have any other questions I want to put, Sir James.

Now, Sir Wilfred Fish has not talked up till now. We have spent a great deal of time with Mr. Balding and his colleagues, we have had a great deal of information from them and I think we understand the problems confronting the general dental practitioner. We understand their sense of grievance with the way in which dental remuneration has been dealt with by the Government since the war. We have had some explanation from the Government about why it has been dealt with in that way and the whole matter is now under review. I do not know if you could help us about this: we know that the earnings of the average dentist depend on the number of treatments that he can put into his 33 chairside hours or whatever number of chairside hours a week he works and we know that these treatments have been worked out in point of time by the Penman working party. Would you think, Sir Wilfred, that these things ought to be reviewed from time to time in the light of the progress of knowledge and improvement in appliances and technique and so on, that the timings of dental operations ought to be periodically reviewed?—*Sir Wilfred Fish*: I think it would be wrong to say that our Faculty has considered that side

of the problem at all and I do not think it would be right to express an opinion from the Faculty. If you were merely asking for a personal opinion on the matter that would be quite a different thing. Even so, I do not know that either of my colleagues would wish to comment on it. I do not feel in a position to comment on that myself. If you say do I think that the method of remuneration is the best that can be devised, and you ask me personally, I should be doubtful.

4239. Would you wish to suggest any other method, Sir Wilfred?—I would rather not, Sir, because all kinds of complications come in, but some of the points on which I am quite sure it would be fair to comment are these. It is wrong if, as we have been assured, though we do not know it of our own knowledge, the pattern of earnings of a dentist falls off as he gets older; that would hardly seem to be a reasonable state of affairs.

4240. We are given to understand that that is because owing to the extraordinarily tiring nature of his work a dentist, after he gets over a certain age, simply cannot put in so many operations in the course of the day.—There are other matters about it too. As a man gets older he has wider experience and ability and may prefer to do these things in a much better way, in a way he finds has advantages as his experience develops.

4241. *Chairman*: We understand this pattern existed before the Service and quite independent of it, that the dentists were at their peak earning in the earlier middle age.—I can discuss it for hours but I do not think it is appropriate to discuss it as a representative of the College. We have an enormous number of Licentiates of this College. Actually one-third of the profession today hold the L.D.S. of the College of Surgeons but the College is concerned with their examination and their post-graduate training, with providing them with a museum and library facilities and with carrying out research and it does not make a study of the conditions of remuneration in general practice.

We are much more concerned with the consultant aspect of the case and I think it would be quite wrong for me to express a personal opinion simply

because I happen to be here. I do not know whether Sir William would care to comment on general practice. Neither of us has had any recent experience of it and Professor Bradlaw is in the same position because he has been a professor in the Durham University for a number of years. I do not know if he has any comment.

4242. *Sir Hugh Watson*: On that view may we take it that you regard yourselves as representing largely the dental consultants and that really the problems which confront you in your profession are very similar to those which confront Sir James in his profession?—Yes, very similar indeed, but we would just like to say that we would not for one moment have it thought that we are not concerned with the Licentiate who is not a consultant. We are very much concerned with his post-graduate education and with research that may help him but we are not concerned with his conditions of work, if I may put it that way.

4243. Or his remuneration?—Yes. But we have, as you know from our written evidence, some serious concern about the situation of the consultants and in particular about the shortage of consultant posts in the country in dentistry. That is a matter which we feel is extremely important.

4244. I suppose, Sir Wilfred, the shortage of consultant posts is a matter which depends upon the extent to which a need for consultants can be established? At least I am putting that the wrong way round but you see what I mean?—Yes.

4245. Whose business is it to appoint consultants?—May I ask Sir William to deal with that?—*Sir William Kelsey Fry*: To take you into the history, we are a very young profession as compared with general surgery. Before the Health Service came in there were few dental consultants with a result that when the Health Service was introduced there were very few consultants made because there were very few men of consultant status; the rest were put on the hospital list as S.H.D.O. Now since the Health Service there is quite a considerable number of keen men who are taking higher degrees and are anxious to get into the Health Service, I think, more or less, on a full-time basis. It has

been the function of the Faculty for the last ten years—and we have only been formed ten years—it has been our function to encourage men to work up for the consultant status. It is absolutely amazing to me that when we started ten years ago there were five men applying and now this term there are 60. There is an enormous influx of brilliant young men coming into the dental profession. These are the men with whom I mix and they are all men who are anxious to get into hospital service. But as we have already heard it is most frustrating to learn the length of time most of the senior registrars have to wait for appointment. I happen to know a Regional Board where there are 33 sessional places a week, that is three consultants to the whole of one Regional Board. If you could imagine a medical service without any specialists! But there is a tremendous need for consultant advice. You have heard about orthodontics; here are men thrown out into practice just qualified, doing specialist work without any consultant to advise them. I think there would be a great saving to everybody concerned if there were consultant posts in all the Regional Hospital Board areas.

4246. Whose business is it to appoint them?—The Regional Boards'. The Regional Boards are, as everybody knows, hard up for money and there are always expanding medical requirements. I will not say that dentistry has been a Cinderella but there is always difficulty in getting money. There was a time when University Grants earmarked grants to get money for dentistry. I seriously put it to the Commission that, in the same way as mental health where you have had to earmark money, I do not see any hope of getting a reasonable consultant service in this country without having money earmarked like that. Men are coming in, doing medicine, they are taking their Fellowship, they are going through the whole course. I admit they can go back into practice if they fail but they are all really dissatisfied men and unless we can get more consultant appointments the intake of these men is going to dry up.

4247. *Sir William*, there are two reasons why there should be consultants: one, that there ought to be a reasonable number of consultant posts to satisfy the ambitions of competitive senior registrars. But apart from that I understand

that what you are telling the Commission is that there is need throughout the country for a large number of consultants in dentistry?—Not a large number, an adequate number. In the Region I mentioned we only have three for three million people. It seems fantastic. I am not asking for large numbers.

4248. *Chairman*: Three dental consultants?—Three full-time dental consultants to three million people.

4249. And some part-timers?—No. There were 33 half sessions, notional half days.—*Sir Wilfred Fish*: I think, Sir, there is a figure of one dental consultant to 300,000 of the population.—*Sir William Kelsey Fry*: That was what was suggested when the Health Service was started.—*Sir Wilfred Fish*: That is one of the earliest suggestions but it is some kind of yardstick.—*Sir William Kelsey Fry*: Professor Bradlaw may have some other figures.

4250. *Chairman*: According to Appendix A of the Health Departments' factual memorandum, there were 282 whole-time dental consultants in 1955, is that right?—*Professor Bradlaw*: May I help you. The latest figures are 772 consultant sessions in England and Wales in 1956. Those are the latest available figures.—*Sir William Kelsey Fry*: That includes all Universities, full-time professors at teaching hospitals.—*Sir Wilfred Fish*: A very large number of consultants only do one session or one or two sessions a week. That is not the whole-time equivalent of anything like 700 dental consultants and you must bear in mind in considering that that you are not dealing only with a single aspect of dental specialisation. You are dealing with orthodontists, surgeons, teachers and the like so that the situation which Sir William Kelsey Fry has represented in respect of his region is not only duplicated in other regions but by and large it is very much worse.

4251. On page 5 of the Ministry memorandum there is given a total of 676 part-time sessions plus, I suppose, 27 times eleven whole-time ones which made about 950.—*Professor Bradlaw*: Yes, Sir, the figures I have given you are the most recent figures available to the Ministry.

4252. Does that mean that your sessions include all the whole-timers?—Yes, Sir.

4253. *Professor Jewkes*: And when the Ministry of Health gives us statistics showing the number of dental consultants as 249 that means part-time and full-time?—Yes, Sir. It is possible to make available to you the break up of whole-time and part-time and show sessions done by part-timers but I would welcome an opportunity, Sir, if it is not too late, to say something on this problem from an entirely different aspect.

4254. *Chairman*: Yes, I think so. Some of the figures are a little bit confusing here but the general picture is not very much vitiated by that.—No, Sir. What I would like to address the Royal Commission's attention to is a different aspect of the matter altogether. It is not only a question of the unsatisfied needs in the regions. It is the effect on recruitment to the profession and the attitude of the members of the profession in consequence. You will appreciate, Sir, that a very substantial number of those on the Dentists Register who have dental qualifications have additional qualifications. I am speaking from memory, I have a figure of some 2,000 odd. Of the Board of the Faculty which we represent there is only a single man who has not got a medical qualification. I doubt very much if there are any staff on the London teaching hospitals, except one or two, who have not medical qualifications as well as higher dental qualifications.

If I may speak of Sir William Kelsey Fry and Sir Wilfred Fish, both of them, when they were younger men, have held medical appointments. Sir William has made perhaps the greatest contribution which has been made to oral surgery. Sir Wilfred Fish, a doctor of science, has contributed research which has altered our thinking. The point that I want to bring home to the Commission, if I may, is that unless there are opportunities for men of this calibre you will not only continue the frustration which exists now in the dental profession—as a dean of many years' standing I know this very well—but you will be turning away from the dental profession the very elements which we would wish to see entering a learned profes-

sion on whose integrity, on whose scientific knowledge and whose maturity we must look for advancement and for co-operation with their medical colleagues.

Chairman: I think we have got that point.

4255. *Sir Hugh Watson:* Yes. In view of what Sir Wilfred Fish has explained about the functions of the body which he represents, they are very close in their interests to those of the side of the Royal College which Sir James represents. I do not think we can usefully pursue this matter further unless there is any matter you wish to develop, Sir William?—*Sir Wilfred Fish:* I agree from the general point of view, that has been our intention and ideal. It has, in fact, been our policy to ensure that dental consultants had a corresponding course of training to those in any other branch of surgery and, as you know, we give them approximately the same kind of course, the same number of years' training and they must take their Fellowship of the College in dental surgery.

4256. *Chairman:* And, Sir Wilfred, you do not in the consultancy branch have this same trouble about getting old too early, your earning power falling off after 35. You would not think you would be parallel to the medical profession there, would you, much more than in the general dental practitioners' branch?—You mean the dental consultant is not suffering from the diminishing of income as he gets older?

4257. Yes.—There are so few, if you mean in private practice.

4258. What I mean is that there is no reason why they should suffer the falling off to the same extent?—No, because they would become more competent and in private practice normally their fees would go up which is normal in private consultant practice; as a man gets older he becomes better known. But, of course, in the Service it is purely a question of distinction awards, which are not reduced.

4259. At any rate salary does not fall off?—No.—*Professor Bradlaw:* If I might come in briefly, Sir, unfortunately private practice and domiciliary visits for dental consultants are so limited it would not make very much difference if their physical powers diminished.

4260. *Sir David Hughes Parry:* But the merit awards are there?—Yes, Sir.

4261. And they are not taken away once given?—No, Sir.

4262. *Chairman:* There was one point which arises from that for you, Sir James. Do the College consider that there is any case for a higher basic rate of salary for surgeons, for any particular group of surgeons or indeed any surgeons at all as compared with physicians or anyone else, or do you consider that all consultancies are the same? The latter, I think, has been the attitude hitherto.—*Sir James Paterson Ross:* I think, Sir, that has been accepted.

4263. It has been put to us by one branch of surgeons that there ought to be something special for them.—I have never heard that put forward. I must say I have never thought of it. Of course it is interesting that the consultants generally have been made equal as far as their salaries are concerned in the Health Service whereas certain branches—we are speaking in committee now—for example anaesthetists, I think, in the past got smaller fees than surgeons did and therefore they have had a relative increase in salary. I think I am right in saying that, am I not? But as regards one branch of surgery and another branch of surgery I would not have thought there was any ground.—*Sir Harry Platt:* I think as a College we really could not support that idea. Personally the idea of rewarding the exceptions—this is my own personal opinion—of certain super scale payments to attract to certain positions a man, say, from Canada or the United States, might have something in it. But to say that a thoracic or heart surgeon or neurosurgeon, long hours and so on, I know the argument, demands more than surgeons in other fields, I do not think we could support that at all. We are not really claiming that the surgeon should be better paid than the physician. The merit award has made that difference between all consultants that some are more equal than others.

4264. *Professor Jewkes:* But you are suggesting that the earnings of a consultant in some of these other countries, United States, and so on, are so much higher than they are here that if we are ever going to get these people to come across we have to have a higher limit?

—That is my own personal view for certain very important fields.—*Sir James Paterson Ross*: For appointments rather than for a class of specialists.—*Sir Harry Platt*: If you want to get a man as in the United States you have to offer him more.

4265. *Chairman*: You want these special awards attaching to posts?—We are not recommending that as a College. We have discussed it and our Council was not unanimous, Sir.

4266. I hope you do not think we have questioned you insufficiently, Sir William and Sir Wilfred, by devoting such a short time to the special problems of dentistry but I do not think there are any other questions we have on that subject.—*Sir Wilfred Fish*: We are only concerned that our consultant branch should develop. When Sir William says we are a young profession I was thinking of

the early days in dentistry; we are just about to celebrate our centenary in the College of Surgeons. We are not as young as all that but we are a small profession and it is very important certainly that the consultant branch should be developed and not be stinted in the number of appointments that are made either for the welfare of the people's health directly—because they do need consultant treatment—or for the welfare of the profession where they can only have one object and that is to give the public better treatment. Therefore I think on both grounds it is very important that there should be an increase in the number of consultant posts and for our part we will undertake to see that our consultants are well trained and deserve any encouragement they are given.

Chairman: I think that concludes this session. Thank you very much.

(The witnesses withdrew)

MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on
Doctors' and Dentists' Remuneration

SEVENTEENTH DAY

Friday, 25th April, 1958

Present

SIR HARRY PILKINGTON (*Chairman*)MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.SIR DAVID HUGHES PARRY, Q.C.
SIR HUGH WATSON, D.K.S.

MR. I. D. MCINTOSH, M.A.

MR. W. A. FULLER, D.S.C. (*Secretary*)MR. J. B. HUME (*Assistant Secretary*)

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS

Memorandum of Evidence to the Royal Commission on Doctors' and Dentists'
Remuneration

The objects of the Royal College of Obstetricians and Gynæcologists, as declared by its Royal Charter, are "the encouragement of the study and the improvement of the practice of obstetrics and gynæcology, subjects which should be inseparably interwoven".

The affairs of the College are governed by an elected Council, which itself elects the President, Vice-Presidents, Honorary Treasurer and Honorary Secretary. London, England and Wales, Scotland, Northern Ireland, Eire, are represented on a geographical basis by a specified number of Councillors.

The Council of the College is precluded by the terms of its charter "from engaging in any transaction with a view to the pecuniary profit or gain of the individual members thereof". For this reason it cannot make detailed recommendations on rates of pay.

It wishes, however, to draw the attention of the Royal Commission to two important points:—

- (i) It is of the greatest value to the patient that obstetrics and gynæcology should be practised together as one subject at consultant level, thus forming, with medicine and surgery, the three branches of modern medicine.
- (ii) Due consideration should be given to the fact that the practice of obstetrics makes extra demands on those who undertake it. The amount of emergency work, especially by night, which cannot easily be delegated by reason of its character, is far higher than in any other branch of medicine.

If the statements made above, which Council believes are important for the well-being of the service, were generally accepted and implemented in practice, it would still follow that for an interim period there would be certain specialists practising obstetrics only and paid at a lower rate than those of their colleagues who combined obstetrics with gynaecology and held consultant (as opposed to S.H.M.O.) posts. The Council believes that all hospital obstetric beds should be under the control of consultant obstetricians and gynaecologists.

The Council of the Royal College of Obstetricians and Gynaecologists agrees in the main with the statement prepared by the Joint Consultants Committee and with Part I of the evidence submitted by the Royal College of Physicians. It has not yet had an opportunity of considering any further evidence submitted by the Royal College of Physicians, the Royal College of Surgeons or other bodies.

With these general observations, the Council would make the following comments on the document submitted by the Royal Commission. There are certain questions, particularly some relating to general practice, on which Council felt it was not in a position to make worthwhile comment. For this reason no answer has been given to questions (vii) (a) and (b), (ix), (xi), (xiv), (xvi), (xix), (xxi).

The following observations are made on the remaining questions asked by the Royal Commission.

(i) *The quality and quantity of recruits*

This is a matter on which the universities, undergraduate medical schools and pre-clinical training units are best able to speak. It is not until their pre-registration year at the earliest that these recruits come to the notice of the College.

(ii) *The quantity and quality of newly qualified doctors*

It would appear that there is a sufficient number of qualified doctors to fill the obstetric and gynaecological house posts. The Royal College of Obstetricians and Gynaecologists has no evidence to suggest that the standard of academic achievement of the newly qualified doctors is deficient, yet knows that there has been a change in the type of person taking up medicine as a career. There are fewer young doctors drawn from professional classes and particularly from doctors' homes. While this is not a bad thing, *ipso facto*, Council believes that it indicates that the professional classes regard medicine as a less satisfactory career than previously and if this is so, it should be viewed with misgiving as the tradition of service and sense of vocation so essential to the practice of medicine at its highest level, are less easily acquired by those brought up in homes without this background.

(iii) *Wastage of men and women during training and in the first few years after qualification*

This appears to be minimal in obstetrics and gynaecology. Relatively few who start their training in these subjects abandon it for specialisation in other branches of medicine.

(iv) *The cost and duration of training*

The requirements of the Royal College are confined to postgraduate training and are outlined in the regulations. At present a minimum of three years residence in approved hospitals is necessary for candidates for the Membership but this may be increased. Candidates for the Diploma in Obstetrics (a general practitioner's and not a consultant's qualification) are required to hold a six months resident appointment in that subject, again in an approved hospital. It is the opinion of the College that every general practitioner practising obstetrics should have held a resident postgraduate appointment in obstetrics.

All the posts referred to above are paid posts. The Council would not consider that there was a case for supplementary grants except under very exceptional circumstances, which would be more likely to apply at registrar level. It occasionally happens that a post in obstetrics and gynaecology, or in another closely

allied branch, e.g., pathology, biochemistry or endocrinology, in a good teaching unit would be of great advantage to a trainee already moderately senior. His commitments and responsibilities might be such that he would be unable to meet his financial obligations on the salary for a junior post, and be forced by circumstance to take a registrar post under conditions less favourable for his training. It would be an advantage under such special circumstances, which admittedly are rare, if a grant could be made available to assist in the training programme.

(v) *The position and prospects of a newly qualified doctor*

The College submitted a memorandum relevant to this question, to the Willink Committee in July, 1955, a copy of which is appended.

(vi) *Any trend to excessive resort to certain branches of the profession*

The College has no evidence to suggest that there is in relation to the other branches of medicine an excessive number of specialists in training today in obstetrics and gynaecology. The number is probably influenced by the exacting demands of this type of practice.

(vii) (c) *The relative advantages and disadvantages of a whole-time consultant in the National Health Service*

The grades referred to in questions (c) to (f) inclusive are grades in which the College is interested. The whole-time consultant has many disadvantages under the present arrangements. It is impossible for him to fulfil his duties unless he has a 24-hour telephone service in his home, and a car available night and day—yet he obtains no tax relief at present on these essential items. Membership of learned societies, and the study of scientific journals are an important need of a practising consultant. Council feels that the expense incurred in connection with all the above, should be allowed for income tax purposes.

It is in the interest of both patients and consultants that there should be an opportunity for private practice. Whilst it is admitted that facilities exist, the cost to the patient is often prohibitive, even though in some instances offset by contributory insurance schemes. These do not, however, contribute to expenses for normal midwifery. Thus, beds are occupied by many patients who are able, and would prefer, to make a contribution for the satisfaction of being a private patient under the clinical care of the doctor of their choice, but who are unable to pay the high hospital charges now demanded. An extension of private bed accommodation with a reduction in the costs—in recognition of the fact that patients occupying such accommodation are not claiming accommodation under section (iv) or (iii) to which their National Health Service contributions entitle them—would result in an increased income to the exchequer and the consultant.

If increased private bed accommodation were provided it might well result in fewer consultants having a maximum number of sessions and more with a reduced number. The Council considers that a hospital is better served by two or more consultants with fewer sessions than by perhaps only one consultant with a maximum number of sessions. Because of the exacting demands of obstetric practice it is humanly impossible for one consultant to be constantly on duty day and night. There must therefore be more than one consultant available in a given area if there is to be adequate specialist cover for holidays, illness and absence from other causes, quite apart from the demands of the day to day control of the obstetric and gynaecological service. This is particularly important in scattered areas, but without means of securing a full income, that is by private practice, such an arrangement is impracticable.

(viii) *The difficulties encountered by members of the Registrar grades*

The present system of staffing hospitals is dependent to a great extent on registrars, particularly of the Senior Grades, whose posts are regarded as training for consultant responsibilities and practice. With the limited number of consultant posts all registrars cannot hope to achieve consultant status and at the end

of their term of office those who do not secure promotion in the special branch of medicine in which they have trained, find themselves unable to use their training in other branches of the profession.

They also experience great difficulty in entering general practice because they are not equipped for this work. An increase in the established number of consultant posts on the lines suggested in (vi) would partially mitigate this *impasse*. Also encouragement should be given to the system of allowing men and women who have had specialist training as registrars, and yet have been forced into general practice because they are unable to achieve consultant status, to be given part-time employment in the hospital service as clinical assistants.

(x) *The importance of private consulting practice as an incentive*

It is true to say that owing to the personal nature of obstetric and gynaecological work there is a considerable demand for private attention which has withstood the non-paying facilities offered by the National Health Service more than other branches of consulting practice. In obstetrics particularly the importance of private practice is an incentive for a young man to enter consultant practice. Obstetric work is arduous and whilst the choice of this branch of medicine is frequently influenced by genuine interest in the work more than by financial considerations it is obvious that the opportunities afforded by private practice cannot be entirely overlooked. As already indicated under (vii) Council holds the view that if facilities for private care were made available at reasonable cost it would be to the benefit of the public, the exchequer and the consultant.

(xii) *Comparative treatment for Income Tax purposes*

Council believes that whole-time and part-time consultants should have similar treatment by the Inland Revenue Department over such matters as telephones, cars, subscriptions to learned societies, journals, etc., which are as essential to the one as to the other.

(xiii) *Any anomalies in the methods of payment of any branch of the profession*

The work of the general practitioner-obstetrician entails responsibility and much time. It is important therefore that such practitioners should have adequate time for this work without suffering financial loss. The position in regard to remuneration of general practitioner-obstetricians is anomalous. If a practitioner on the Obstetric List is engaged to attend a domiciliary case and carries out the minimum prescribed—two ante-natal and one post-natal examinations with attendance at the delivery if required—he is paid by the Executive Council seven guineas, the duration of his attendance after the confinement being limited to 14 days. If he is called to an emergency under the Medical Aid Scheme he is paid by the Local Health Authority under different arrangements and his attendance after delivery is for 28 days. Further reference to this anomaly is made in the College Report on the Obstetric Service under the National Health Service, July, 1954, a copy of which is appended. Council submitted to the Cranbrook Committee evidence (a copy of which is included)² to show what excellent work general practitioner-obstetricians can accomplish, when associated with a consultant team. It holds the view that the general practitioner-obstetrician should be adequately reimbursed for the increased responsibility he accepts in this type of work.

(xv) *General comments on the system of merit awards and the method of allotting them*

Council is aware of the criticisms made against the system of merit awards and has considered alternative proposals, such as recognising selected posts rather than individuals. It is convinced that it is more than ever important under the National Health Service in which all consultants are considered officially as being clinically equal, that there should be some system of incentive for, and recognition of, outstanding work. While it is unable at the moment to suggest an alternative to

² These two documents already published by the Royal College are not reproduced in this volume.

the present merit award system, which appears to be working well, it believes that the possibility of providing better alternatives should be kept constantly under review.

(xvii) *Special considerations of which account ought to be taken in discussions of medical remuneration,*

and

(xviii) *Specific proposals for medical remuneration*

The Council does not wish to comment beyond drawing attention again to the heavy demands of obstetric work and the impossibility of arranging clearly defined sessions for much of the work involved.

(xx) *Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration*

The Council believes that the Whitley machinery has proved inefficient as a means of adjusting remuneration for the profession. It regrets the publicity which has inevitably been associated with the attempts to date to obtain adjustments of remuneration. Council is convinced that when doctors entered the National Health Service in 1948 they did so believing that their economic status in the community would be safeguarded by the implementing of the reports of the Spens Committee. Recent events would suggest that remuneration for the profession has become increasingly a political matter. Council holds the view that this is contrary to the spirit in which the profession entered the Service in 1948, and believes that considerable harm has already been done both to the Service and to the profession. It believes moreover that if the recent attitude of the Government to the claims of the profession is persisted in the result may be serious for all concerned. For these reasons Council is attracted to the concept of an impartial, neutral body acting as an intermediary between the profession and the Government. A small permanent committee, as advised by Lord Moran, with its terms of reference to keep under constant review the scales of remuneration within the National Health Service, and to advise the Government when adjustments were indicated, would seem to Council to be a practical way of achieving these aims.

Signed on behalf of the Council,

ANDREW M. CLAYE,

President.

January, 1958.

APPENDIX

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS

Memorandum to the Ministry of Health (Willink Committee)

on the Number of Medical Practitioners and Medical Students likely to be engaged in Obstetrics and Gynaecology in the future.

Memorandum from The Royal College of Obstetricians and Gynaecology on the number of Medical Practitioners likely to be engaged in Obstetrics and Gynaecology in the future.

The following report is presented in response to the invitation of the Committee appointed under the Chairmanship of the Rt. Hon. Henry Willink, M.C., Q.C., with the following terms of reference:

"To estimate, on a long term basis and with due regard to all relevant considerations, the number of medical practitioners likely to be engaged in all branches

of the profession in the future, and the consequential intake of medical students required."

The report is based on conditions appertaining at the present time: no attempt has been made to anticipate changed conditions.

The present position

In order to discover how many practitioners are engaged in obstetric and gynecological practice in all grades in the National Health Service in England, Scotland and Wales, the College has prepared a questionnaire for Boards of Governors and Regional Hospital Boards, the correlated replies to which are given in Appendix A. The College has also obtained statistics from the Ministry of Health and the Department of Health for Scotland. These statistics, together with other information, were published in the *British Medical Journal Supplement* 26/2/55 p. 66, and these are given in Appendix B.

From the answers to the questionnaire it seems that there is a total number of 708 Consultants and S.H.M.O.s employed in England, Scotland and Wales (not including 9 vacancies in establishment or a required increase in establishment of 13). But in the *B.M.J. Supplement* the total number, obtained from the Ministry of Health, was given as 580. The difference of 128 may be due to Consultants working for more than one Hospital Board and therefore being included in answers to the questionnaire by more than one Board. For this reason the total number of Consultants and S.H.M.O.s is assumed in this memorandum to be 580. Since Senior Registrars, Registrars and House Officers are not usually employed by more than one Hospital Board the figures relating to these appointments in the questionnaire are considered to be correct. In the following totals vacancies in establishment are included, but required increases in establishment are stated separately. In accordance with the opinion of the Council of the College that the posts at present filled by S.H.M.O.s should in fact be filled by Consultants, the two appointments have been considered together.

The present position in England, Scotland and Wales can be summarised as follows:—

(a) Consultants and S.H.M.O.s.

Total number 580.

(In the replies to the questionnaire there were 623 Consultants and 94 S.H.M.O.s, including 9 vacancies in establishment. Of the Consultants, 526 were part-time with an average of 6 sessions each. There was an increase in establishment required of 13 Consultants and no S.H.M.O.s.)

(b) Senior Registrars.

Total number : 115 (including 5 vacancies in establishment).

These are distributed as follows:—

1st year	...	...	...	...	...	36
2nd year	...	...	...	...	...	22
3rd year	...	...	...	...	...	14
4th year	...	...	...	...	...	14
5th year						
or supernumerary or transitional	...	...	...	...	...	29

(In addition there was an increase in establishment required of 3 Senior Registrars. The above statistics do not take into account those who have finished their consultant training but who have no appointment. There is no way of estimating their number.)

(c) Registrars.

Total number : 232 (including 20 vacancies in establishment).

These are distributed as follows:—

1st year	...	...	...	...	111
2nd year	...	...	...	...	121

(In addition there was an increase in establishment required of 8 Registrars.)

(d) Senior House Officers and House Surgeons, Registered and Pre-registration.

Total number : 669 (including 16 vacancies in establishment).

These are distributed as follows:—

Senior House Officers	...	...	...	176
Registered House Surgeons	...	...	...	153
Pre-registration House Surgeons	...	...	...	340

(In addition there was an increase in establishment required of 6 Senior House Officers, 2 Registered House Surgeons and 1 Pre-registration House Surgeon.)

The Service Provided at Present.

As shown in Appendix B there are 19,924 obstetric and 10,443 gynaecological beds in England, Scotland and Wales.

From this it can be worked out that there is:—

- 1 Consultant or S.H.M.O. for every 34.5 obstetric beds and every 18 gynaecological beds.
- 1 Senior Registrar or Registrar for every 57.5 obstetric beds and every 30 gynaecological beds.
- 1 Senior House Officer or House Surgeon for every 30 obstetric beds and every 15.5 gynaecological beds.

The Training of Consultants at Present.

If the average length of service as a Consultant is 30 years there will be an average of 19.3 consultant posts vacant annually through retirement. In Appendix B it is anticipated that between 1963 and 1974, the average number of Consultants and S.H.M.O.s retiring each year will be 20. At the present rate there will be an average of 23 Senior Registrars, 116 Registrars and 1,162 Senior House Officers or House Surgeons finishing their appointments each year. Thus for every Senior Registrar who completes his training there are 5 trained as Registrar and 50 trained as Senior House Officer or House Surgeon.

The future position

At the present time 65 per cent. of births are institutional (see Appendix B). It is the policy of the College that there should be beds available in hospital for every expectant mother who needs or wishes to be confined in hospital. It is anticipated that the total number of institutional births might increase to 90 per cent. Nevertheless it is probable that this increase will be mainly in General Practitioner Maternity beds which means that little addition to the number of obstetricians in training will be needed, because these beds will be staffed by General Practitioner-Obstetricians who will be able to admit abnormal cases to an associated Hospital Maternity Department, in which there are already beds available for such emergencies.

It is assumed, moreover, that the proportion of part-time and full-time Consultants will remain the same as at present.

Thus if the requirements for increases in present establishment are taken into account the future needs will be:—

(a) *To run the Service.*

Consultants	...	...	...	...	...	...	600
Senior Registrars	...	...	...	...	...	...	120
Registrars	...	...	...	...	...	...	240
Senior House Officers	...	...	...	...	...	...	180
Registered House Surgeons	...	...	...	...	...	...	155
Pre-registration House Surgeons	...	...	...	...	...	...	340

Thus, as a rough guide, there will be:—

- 1 Consultant for every 35 obstetric and 20 gynaecological beds.
- 1 Senior Registrar or Registrar for every 55 obstetric and 30 gynaecological beds.
- 1 Senior House Officer or House Surgeon for every 30 obstetric and 15 gynaecological beds.

It is suggested that if there is an increase in the number of Consultant Hospital beds, in those areas in which there is at present a shortage, there should be a corresponding increase in personnel although the general ratio suggested above may not be applicable to all hospitals, for the individual requirements vary with the type of work carried out.

(b) *To train Consultants.*

If there are 20 Consultants reaching the age of retirement each year there should be 25 Senior Registrars fully trained annually to fill the vacant consultant posts and to allow for those who go abroad or take up academic posts or go into another branch of medicine.

If the training of a Senior Registrar is for five years this means a total at any one time of 125 Senior Registrars. But in order to run the Service nearly three times as many Senior Registrars and Registrars will be needed. It is suggested therefore that approximately 250 Registrars are trained at any one time of whom only one in five will be selected to proceed to Senior Registrar to train as a Consultant, *i.e.*, 125 new Registrars each year. This means that selection as a Senior Registrar almost ensures a Consultant post when the training is complete.

If, on the other hand, it is considered that the training of a Senior Registrar is complete at the end of four years (instead of five years) a total of 100 Senior Registrars will be needed to replace Consultants at the rate of 20 a year. But in order to run the Obstetric Service a total of 360 Senior Registrars and Registrars will be needed and therefore there will have to be 260 Registrars at any one time, or 130 new Registrars appointed each year, of whom about one in five will continue to specialise in Obstetrics as a Senior Registrar.

Because of the importance of their training it is suggested that Senior Registrars should be trained partly in a teaching hospital. In many instances this will probably be in joint appointments with Regional Hospital Boards.

It is realised that there should be a few additional Registrar and Senior Registrar posts for the training of men from the Dominions who will presumably return there when their training is completed.

There are at present approximately 345 Pre-registration House Surgeons and 155 Registered House Surgeons being employed at any one time. Since these appointments are each for six months it means that approximately 1,000 Pre-registration and Registered House Surgeons will be trained in Obstetrics and Gynaecology (or both in combined appointments) each year. This figure represents the number of students required to fill these posts annually. They will presumably also undertake other House appointments in the various branches of Medicine and Surgery before or after undertaking an appointment in Obstetrics or Gynaecology. From this number will be those who are to become Senior House Officers (at

the rate of 180 each year), Registrars (at the rate of 125 each year), Senior Registrars (at the rate of 25 each year) and, finally, Consultants (at the rate of 20 each year).

Thus it can be worked out that to replace a Consultant and to run the Service on the present system it will be necessary to train at the same time 1·25 Senior Registrars, 6 Registrars and 60 House Officers.

The above estimate assumes that the pattern of hospital staffing remains as it is at present and makes no allowance for the time occupied in National Service.

Signed on behalf of the Council of the Royal College of Obstetricians and Gynæcologists,

A. A. GEMMELL,

President.

July, 1955.

STUDIES ON ENVIRONMENTAL AND BIOGEOCHEMICAL PROCESSES IN THE INTERIOR OF BASINS OF

Department of Health Services, University of Washington, Seattle, Washington

Figure 1: Schematic representation of the experimental design. The figure shows a timeline of the experiment. It starts with a 'Pretest' phase, followed by a 'Main Experiment' phase. The Main Experiment is divided into two parts: 'Part 1' and 'Part 2'. Part 1 involves a 'Pretest' and a 'Main Experiment' with 'Condition 1' and 'Condition 2'. Part 2 involves a 'Pretest' and a 'Main Experiment' with 'Condition 1' and 'Condition 2'. The timeline ends with a 'Posttest' phase.

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DETAILS OF CHEMICAL AND ORGANOLOGICAL RESEARCH IN THE

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 2. **What are the research objectives?**
 3. **What is the research methodology?**
 4. **What are the results of the study?**
 5. **What are the conclusions of the study?**
 6. **What are the limitations of the study?**
 7. **What are the implications of the study?**
 8. **What are the future research directions?**
 9. **What are the contributions of the study?**
 10. **What are the key findings of the study?**
 11. **What are the main results of the study?**
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APPENDIX B

June, 1955.

Information received from the Ministry of Health and the Department of Health for Scotland regarding evidence to be submitted to the Willink Committee.

	<i>England & Wales</i>	<i>Scotland</i>
Obstetric Beds	17,171	2,753
G.P. Maternity Beds	2,449	423
Total Births	690,823	94,714
% Institutional	64.3	70
Gynaecological Beds	9,118	1,325

British Medical Journal Supplement—26/2/55 p. 66.

OBSTETRICIANS AND GYNÆCOLOGISTS

Total Consultants and S.H.M.O.s in Great Britain (*i.e.*, England, Scotland and Wales) 580—(England and Wales 413 Consultants and 87 S.H.M.O.s—separate figures for Scotland not available).

Between 1963-74 the average number of Consultants reaching age 65 each year is 20—before 1963 the number is less.

Total Senior Registrars in Great Britain (*i.e.*, England, Scotland and Wales) is 71:—

1st year	... ..	26
2nd year	... ..	15
3rd year	... ..	17
4th year	... ..	13

There are however a number of additional people at this level.

Examination of Witnesses

PROFESSOR A. M. CLAYE, *President*

MR. T. L. T. LEWIS

MR. H. J. MALKIN

MR. J. H. PEEL

on behalf of the Royal College of Obstetricians and Gynaecologists
Called and Examined

4267. *Chairman*: Professor Claye, we have had your memorandum, which we have read with much interest. You probably know that we have already seen your sister Colleges, the Physicians and the Surgeons, and we have also seen the Colleges in Scotland, so that we have covered fairly fully by now a good many of the points of general in-

terest to the Colleges, and we may not need to go into all of them in great detail with you. We hope, therefore, that we shall be able to ask you all the questions we wish to, before lunch today, and that we may finish by then. You will know that this is a public hearing and, therefore, if there are any things you do not want to be published,

you had better not say them. Once yesterday somebody said "Since we are in Committee, I will say such-and-such", but we are not. Anything that is said is liable to be reported. If we press you fairly thoroughly on some of the representations you have made, please do not interpret that as meaning either disbelief or hostility. Equally, do not interpret the fact that we do not ask you about some points as meaning that we think they are irrelevant, or that we accept them; it is just for us to make up our minds on them, in due course.

We have got two eminent lawyers on this Royal Commission, who have done most of the work in going through the submissions and getting an orderly way of approaching our questions, and in this case Sir David Hughes Parry, whom you may already know, is going to take the lead in asking most of the questions. But you will be asked questions by anybody on the Commission, and in your turn I hope you will feel free to let any of your colleagues reply on any subjects that you think are more particularly up their street. We want to get the best of this opportunity.—*Professor Claye*: Yes, Sir.

4268. *Sir David Hughes Parry*: May I say before I begin that, if there is any matter which you would like to add to what you have already said to us, I hope you will take the opportunity when we deal with the different paragraphs?—Yes, I will do that.

4269. Or, if there is any alteration or modification you wish to make there will be every opportunity, and I hope you will take it. Could we begin on the first page? Your paragraph (ii) says:

"Due consideration should be given to the fact that the practice of obstetrics makes extra demands on those who undertake it. The amount of emergency work, especially by night, which cannot easily be delegated by reason of its character, is far higher than in any other branch of medicine."

I wonder if you have any particulars that would help us to see the problem, in the form of statistics, of the number of times a consultant may be called out at night? We have a general impression that the general practitioner and, perhaps, even the consultant, is not called out now as frequently at night as

formerly.—Yes. I think that is true, Sir, but we have not got any definite statistical evidence about this. But I think it is the belief of our Council that, even so, both the consultant and the general practitioner get more calls in this branch, than in others.

4270. But it is a general impression?—We have not got chapter and verse for you.

4271. *Chairman*: When you say that due consideration should be given, what does "due consideration" mean? Are you implying that this particular speciality should be rather better rewarded than other specialties, on account of these extra claims?—I think that this sentence applies more particularly to the general practitioner, Sir, and if the general practitioner has a lot of emergency obstetric work, then he needs the time to do that, and has less time to devote to other work; some sort of adjustment should be made because of that.

4272. *Sir David Hughes Parry*: On page 910, I think you just state that it would be better for us to treat with the Universities and the medical schools, on the question of the quality and quantity of recruits, but in the following paragraph, on the quantity and quality of newly qualified doctors, you say "There are fewer young doctors drawn from professional classes and particularly from doctors' homes", and you believe that this indicates "that the professional classes regard medicine as a less satisfactory career than previously . . ." I wonder if that is an impression. There are many things that contribute to this factor, are there not? I wondered whether this did follow logically.—Yes, I think there are a great many doctors who would have encouraged their sons to go in for medicine, who now try to dissuade them.

4273. Why?—I think that the uncertainty of a good living is greater than it was.

4274. You do not mean to say that they are going into other professions, where they are adequately paid by salary?—No, I do not think so—not exactly, Sir. There is less enthusiasm, I would say, in doctors' households for the profession of medicine, for a great many different reasons, and therefore they do not encourage their sons to the

extent that they did to go into the profession.

4275. But it may well be that there is a call from other vocations, scientific vocations for example. It may be that. —Yes. That is not our point. Our point is that the fathers, themselves, dissuade them because they are not happy about the present set-up of medicine.

4276. *Chairman*: Your College, to a greater extent than the others, I think, covers the Commonwealth as a whole, does it not? —Yes, Sir.

4277. So you might, perhaps, be in a position to say whether this tendency is universal or widespread in many countries. —No. The countries of the Commonwealth that I know best are Australia and New Zealand, particularly Australia, where the arrangement is quite different.

4278. Yes, but by the word "tendency" I mean the tendency to encourage their sons to go into other things, because it has appeared to us that, for instance, there is a very parallel tendency in the United States. I thought that perhaps you, in your College particularly, could give us a few facts as to whether the tendency for doctors' sons not to become doctors is much more marked here than elsewhere, or not. —No, I am afraid I have not got any definite evidence about that, Sir.

4279. Do you think your College would be able to get any, because this is a point that you are rather making, and it is particularly valid if it only applies in this country. —Yes, I have no doubt we could make enquiries and find out. My impression as regards Australia is that the doctors are very happy with their set-up. I heard that time and again.

4280. *Sir David Hughes Parry*: This matter has been suggested to us in other vocations, and we are trying to find out why it is that parents in the medical profession do not encourage their children, if that is so, to take up the career of medicine. It may be that the parents are after a greater measure of security for their children in salaried professions; it may be that the competition of other professions is much greater, and that it is easier now for these young people to get into these professions which are greater in number; it may be that

it has been found to be very difficult to get admission to medical schools—that is a possibility, is it not—and, therefore, many are not encouraged to go in now, because of that difficulty; and it may be that the parents are in an income group where they do not get grants to help their children through University. All these things, obviously, have an effect, as well as those you have suggested, do they not? —On the question of grants, I think that is an important point.

4281. But you agree as to the others? —I wonder if you could just recapitulate briefly.

4282. The first one we have already mentioned. You are not quite certain about that, whether the parents advise their children to go into a more secure profession, whether there is competition from other professions? —Yes, that may well be.

4283. And difficulty of admission to medical schools. —Yes, that was the point I wanted to take up, because I do not really think there is much difficulty about admission to medical schools. The figures that you get are swollen, because so many people apply for several different medical schools and, in fact—certainly in the provinces—we have very little choice with our vacancies about accepting people. I do not know if any of my colleagues would like to make any comment on this.

4284. *Chairman*: Which part of the provinces do you belong to, Professor Claye? —Leeds.

4285. *Sir David Hughes Parry*: That is the impression we also got from Scotland, but it is another impression that I have from London. —Yes, I think that may well be. Two of my colleagues are from London, and are better qualified to answer that than I am. —*Mr. Peel*: I would say that, as far as that is concerned, there is no shortage of applicants to become medical students. And I think there is no great difficulty in choosing suitable candidates. I would agree that it is not all that difficult for a suitable boy to become a medical student. I think that is a fact throughout the country.

4286. *Chairman*: You mentioned "a suitable boy". In Scotland, particularly, we were also told that they were able to exercise rather more selection, if I

remember rightly, with boys than girls, but at any rate the question of girls was quite material.—Yes, I think it is true to say that the medical schools have a fairly fixed quota of the two sexes, and I would say that it probably is more difficult for a girl to take up medicine, than for a boy, and to get a place in a medical school.

4287. *Sir David Hughes Parry*: Who has fixed the number or percentage for the women?—I think that is fixed by the University of London. That is my recollection. At any rate, it is by agreement amongst the various constituent parts of the University.

4288. I thought that the agreement on the University side was that the medical schools should reserve not less than 20 per cent. of their places for women. I think it is left to the medical schools, themselves, to say how many they will take, and I think it may very well be that the medical schools among themselves have reached agreement.—Yes, I think that is quite true.

4289. *Chairman*: Are you feeling that parents are less willing than before to advise their daughters, as well as their sons, to take up either medicine as a whole, or your particular branch of the profession, or is it particularly sons?—*Professor Clave*: I would have thought particularly sons, Sir.

4290. *Sir Hugh Watson*: Whilst giving a certain amount of weight to the various considerations that Sir David has just put before you, Professor, I gather from what you say that your view still is that the principal factor in this matter is the fact that doctors are actively dissuading their sons from following in their fathers' footsteps.—Yes, I think that is so.

4291. Could you tell us exactly for what reasons you think doctors are doing that, because if it is something to do with remuneration, we are here to advise about remuneration, and we would like to know about it.—Yes, I think remuneration has a good deal to do with it, Sir.

4292. From what point of view?—That now, as compared with before the advent of the Health Service, the status of the doctor, financially, is not so good as it was.

4293. That applies to almost all the professions, does it not, Professor?—I suppose it does, yes.

Sir Hugh Watson: I think Sir David and I feel it applies to us.

4294. *Chairman*: And you feel that applies to the general practice branch, as well as the hospital branch?—Yes, I would say so, from the people I have spoken to, Sir.

4295. *Sir Hugh Watson*: Do you feel, Professor—I think this is a matter of some importance—that this is because the level of remuneration of doctors has not been brought up in accordance, roughly, with the standard of living, or is it deeper than that, or what is it?—I think it is partly that, and, of course, you know there is bad feeling on the subject of Spens. The doctors do feel that they have not had a square deal on that, and that no doubt is one thing which will tend to make parents dissuade their sons from going in.

4296. *Chairman*: How long has this dissuasion been going on?—I would say for several years, Sir.

4297. The bad feeling is of more recent growth, is it not, as regards the question of Spens?—Yes.

4298. *Sir Hugh Watson*: There could be no doubt that, at least until 1951, everything was all right, because that was the year in which Mr. Justice Danckwerts pronounced his award, which I think it is fair to say is regarded as not ungenerous by the medical profession.—Yes.

4299. It is also fair to say that the medical profession, themselves, made no claim after that until 1956, as I understand it. So all this bad feeling has arisen since the claim was put forward by the British Medical Association in 1956? Is that right?—I think very largely, at any rate.

4300. I do not want to appear to be cross-examining you or tying you down, but that is only two years ago, you see, and after all this Commission was set up 13 months ago, not so very long after the B.M.A. began to prosecute their claim. You told the Chairman just now that doctors had been dissuading their sons for several years, and I think it is most important that the Commission

should really have some idea why they have been doing that. I know they have, but I would like to know why.—Yes. I think it is true that the profession did not start taking action on remuneration at once. They have a certain amount of feeling that everybody is in this, and they delayed until 1956 because of that, but I think there was some ill-feeling before then.—*Mr. Malkin*: Could I mention two points, Sir? I think there was a little more dissatisfaction among consultants about the interpretation of Spens than among general practitioners in 1952. It was mainly the general practitioners who benefited from the Danckwerts Award. There was a slight adjustment for consultants, afterwards.

4301. In 1954?—Yes.

4302. *Chairman*: That was an adjustment that Sir Russell Brain said restored the balance between the two branches of the profession.—Yes, Sir. It was not viewed quite as satisfactorily by the consultants. Another point, which I think worries a consultant, is the diminishing private practice which obviously affects his remuneration very much, and a lot of us think that the cause of the diminishing private practice is the fact that the patient has to pay so much for private accommodation if he or she wishes to have private treatment.

4303. We will come to that later in your memorandum.—Yes, I appreciate that, Sir, but it is one of the causes arising from the question that Sir Hugh Watson has put about a certain amount of dissatisfaction, and the tendency for doctors not to encourage their sons to follow in their footsteps.

4304. One is bound to take the discouragement or encouragement into the profession as a whole, and not particularly your branch, or the consultancy branch. In your paragraph (vi) you say that there is no evidence to suggest an excessive number of specialists in training today in obstetrics and gynaecology, but I rather gathered that you did not think there was any excessive resort to any particular branch. I rather deduced that from that answer.—Yes, that is so, but our families will see us as their model, and our reaction is that they will go by our experience in making their decisions as to whether they will go into medicine as a whole.

4305. *Sir Hugh Watson*: This pull away from the professions is not confined

to medicine, Professor Claye. There are many reasons why young men are not going into any of the learned professions in the numbers or the proportions which they used to, and Sir David has said some of the reasons. Would you agree that, perhaps, the young man today has more say in this, than he used to have when you and I were younger?—*Professor Claye*: Yes.—*Mr. Peel*: I think it would be reasonable to say on this pull away from medicine that remuneration is only one of the factors.

4306. That is what I wanted to get at. What other factors do you look to?—They not only concern remuneration, but they concern the whole structure of medicine, and the change which has taken place since the introduction of the National Health Service. There are inevitably factors of change between before and after the National Health Service.

4307. Which make the practice of medicine less attractive?—Which make the practice of medicine less attractive.

4308. *Chairman*: That is one reason why I was very much hoping for some factual information from your College, as well as an impression—some factual information about the other parts of the world, with which you deal, where conditions are quite different. I think your College ought to be particularly well-placed to give us some facts on that.—*Professor Claye*: We will think about that.—*Mr. Lewis*: May I raise one point about security? I think it was suggested by Sir David that, perhaps, more secure professions were attracting the sons of doctors. I do not know whether Professor Claye meant it, but I think he implied that, perhaps, more secure professions were attracting the sons of doctors. I think that the impression among doctors is that the profession is if anything more secure now, but at the same time the restrictions are more and the rewards, as has been said, are less. But on the point of security, I would have said that medicine is as secure for a young man to go into, as any other profession.

4309. *Sir David Hughes Parry*: May we move to paragraph (iv) on the cost and duration of training? There are two matters I would like to raise on that. You say "At present a minimum of three years residence in approved hospitals is necessary for candidates for

the Membership but this may be increased." Is there any further information on that?—*Professor Clays*: The College is considering this very question at the moment. As you have said, we are a Commonwealth College and we have agreed a draft here, which has now been sent out to our regional councils in the Dominions, for approval. That will involve an increase in the length of training, if it goes through.

4310. And an increase in the cost? It essentially involves that, does it not?—*Yes*. Of course, they are in paid posts all the time.

4311. But that is the action of the College? It is the College itself which is increasing the length of the training and increasing the cost?—*Yes*. These young men are in paid posts all the time they are training. We hope they will be more effective gynaecologists when they have finished it, than they are now. That is our view.

4312. The other matter arises later on in that paragraph, where you say "It is the opinion of the College that every general practitioner practising obstetrics should have held a resident postgraduate appointment in obstetrics." At present, the man who is doing his year of intern or pre-registration clinical work has got to spend one year—six months in medicine, and six months in surgery—has he not? That is the present position?—*Yes*, but this is very broadly interpreted. Obstetrics is regarded by the General Medical Council as either medicine or surgery, as convenient.

4313. You were not contemplating that the one year should be extended to 18 months? That is all I am asking.—*There is nothing fixed about that, Sir*. Actually, we should be very glad if the obstetric appointment could be done after the pre-registration year, because we think a man is in a better position to profit by it then. The General Medical Council tells us that there are not enough general posts for the available recent graduates, unless some obstetric posts are included, so that it is still true that a great many obstetric posts are pre-registration posts.

4314. And you really are recommending that no-one should go into this kind of practice as a general practitioner, without the six months training?—*We do not want a general practitioner to*

practise obstetrics, unless he has done this appointment after graduation.

4315. You do not go any further than that? As far as the general practitioner is concerned, you do not ask for any special qualifications, other than the six months?—*No*. As you no doubt are aware, we give a diploma for this, but we leave it to the people concerned to judge whether it would be valuable for them to hold our diploma, and at the moment a very great number of them do take it.—*Mr. Peel*: Just listening to Sir David and Professor Clays speaking, I wondered whether they appreciated the point that the year in a postgraduate pre-registration appointment, which is made compulsory by the General Medical Council, is something every graduate is going to go through. We believe as a College that only a certain percentage of general practitioners should practise obstetrics, and we feel that it is the men who have had special postgraduate experience who should fall into that group. Therefore we should not be in favour, I do not think, of extending the 12 months to 18 months, because we do not feel that it would be necessary for every doctor to have six months' postgraduate education in obstetrics.—*Professor Clays*: That is the position, Sir.

4316. But the young man at this stage does not quite know into what sort of practice he is going.—*Mr. Peel*: *Yes*, that is quite true, but he is not confined to taking an obstetric appointment, necessarily, in his first 12 months.

4317. In paragraph (vi), you say "The College has no evidence to suggest that there is in relation to the other branches of medicine an excessive number of specialists in training today in obstetrics and gynaecology". Are you satisfied that there are enough? You only give the limit on one side. Are you satisfied that there are enough in training?—*Professor Clays*: *Yes*, there are enough, Sir.

4318. You think that it is all right on both sides?—*Yes*.

4319. Then, you deal with the subject of tax relief. We have had a good many representations on this matter, and I think we have got the point here fairly clearly from all the consultant groups. Is there anything further that you would like to add, or have you any particulars,

statistics or anything of that kind to supplement this?—No, I think I cannot put it any better than we put it there, Sir.

4320. *Mr. Gunlake*: There is a point in paragraph (vii) in which I was interested. You say "It is in the interest of both patients and consultants that there should be an opportunity for private practice. Whilst it is admitted that facilities exist, the cost to the patient is often prohibitive . . ." Can you enlarge on that a little, and indicate why it is prohibitive, and to what extent it is prohibitive?—I would like Mr.

Peel to answer this, because I am not in private practice, and my colleagues are.—*Mr. Peel*: I think what the College meant was that the cost of private accommodation in hospitals is extremely high, because it is considerably over and above the overall cost of a bed; the patient is, in point of fact, entitled to a National Health Service bed from his own contribution. By taking the facilities in private accommodation, as he can, he is, in point of fact, not only doing what he wants to do, but is helping the Exchequer by providing additional funds towards the running costs of the hospital. It is merely felt by patients, consultants and general practitioners, that if the cost were reduced, and allowance made for the fact that the patient is relieving the requirement of a National Health Service bed, in point of fact, there would be an increase in the take-up of private accommodation. It would, in point of fact, ultimately be to the benefit both of the public and of the consultants, and, incidentally, to the benefit of the Exchequer.

4321. *Chairman*: How much is there in this in terms of money per week, if you like, for a bed? You are saying that the hospitals are charging too much?—That is so. Obviously, costs have got to be met. You would like us to quote the actual figures. The figures for private accommodation vary between, I would say, a minimum of 20 guineas a week and something like 35 guineas in some of the private beds at teaching hospitals.

4322. *Sir Hugh Watson*: In London?—In London.

4323. *Chairman*: But how much of that do you think is beyond what is the real cost appropriate to that bed?

You are saying that this cost is rather loaded so as to discourage the use of private accommodation?—Supposing the cost per bed in a hospital were £25 a week, then the cost of a private bed—I am only quoting roughly—would be about £30. So that the person contributing towards the National Health Service bed does not take up what he is entitled to, and he has to pay 25 per cent. more than the actual cost of the bed.

4324. *Mr. Gunlake*: Whilst you feel that the cost of the private bed is pitched too high, are you contemplating that it should be set below the economic level? As you know, of course, it is contended in some quarters that drugs should be supplied to private patients from the finances of the National Health Service. Have you anything similar in your minds as regards hospital beds for obstetric purposes?—We know there are arguments on the other side, but I think many people do feel that the cost should be set below the actual cost, because the individual is not taking up his entitlement. I do not know if Mr. Malkin would like to add to that, speaking from outside London.—*Mr. Malkin*: I do not know that I can say much more than Mr. Peel has already said. There is one point which has not been brought out, though no doubt it has on other occasions, that there are two positions. If a patient comes in as an ordinary National Health Service patient, and wishes to have private accommodation, in a lot of hospitals it is possible, by paying another 2 guineas a week, to have private accommodation; but if that same patient wished, at the same time, to pay a surgeon they would have to pay a large amount, as Mr. Peel has said—25 per cent. in excess of the actual cost—and in a way that seems a little hard. I think the figures Mr. Peel has quoted would apply to the provinces, where I come from. They would have to pay 20 guineas a week, but if they did not insist on a particular surgeon doing the job they would get it for 2 guineas a week.

4325. *Chairman*: Most hospitals have their own consultant gynaecologist and obstetrician, who would normally do whatever needed to be done?—Yes, but when the patients go in they are normally asked to say that they appreciate that no particular surgeon will do the work, and only overall control or responsibility is put on to a particular

surgeon. But if they say "I would like Mr. So-and-So to do it", and they want a guarantee of that . . .

4326. Then they have to pay for exercising that preference?—Yes, and we feel that the difference between the two is excessive.

4327. *Sir Hugh Watson*: In the case you are talking about, they would be bringing in a surgeon who is not normally employed as a consultant in the hospital?—I did not mean that at all. Any private bed can be filled by any consultant, but that is unusual, at least, in the provinces.

4328. There is one expression which Mr. Peel used, which I did not understand, when he said that the patient is not taking up her entitlement. What did you mean by that?—*Mr. Peel*: Merely that, in paying her contribution to the National Health Service, the patient, if for example she is going to have a baby in hospital, is not taking an ordinary bed in the hospital; she frees that bed for somebody else. Apropos of that, there is one further point I would just like to mention. We had in mind that there was in obstetrics, rather more than in other branches of medicine, a particular desire on the part of the public for increased private accommodation in hospital, because of the very nature of obstetrics. So many patients do like the personal service of the doctor or obstetrician of their choice, and if private facilities were within reasonable bounds I am quite sure that the patients would take it up very much more than they do. There was the success of various contributory private schemes which were in existence before the National Health Service, which were very popular indeed with the public, but they have all been swept away by the National Health Service; and I think the public is missing something, or that section of the public which would take advantage of that facility is missing something.

4329. *Sir David Hughes Parry*: You partly answered the question which I had in mind to ask. It is based partly on a passage in your answer to question (vii). You say that if there was a diminution in the charges of the hospitals, this would result in an increased income to the Exchequer and the consultant.—Yes.

4330. In other words, it would be very largely to the advantage of the consultant that there should be more private

practice. That is the point that you are making?—Yes, that is so, and we emphasise that, too, apropos of another aspect of the thing. There are a certain number of hospitals in different parts of the country where there may be rather inadequate cover by consultants for the general running and responsibility of the obstetric unit. In other words, it is far better to have two men available at consultant level looking after one hospital than have one who is full-time, because he cannot be on duty the whole 24 hours a day throughout the year.

4331. Many of the other bodies which have been before us have emphasised the importance of the continuation of private practice in the profession. I have not yet a clear view in my own mind of the advantages of being a private patient. I wonder if you could summarise those very briefly for us. You emphasise the importance of private practice for the consultant. Is it purely economic?—I would not say that for a moment, no. I think the economic factor is one factor, and it is an important factor. There are many other factors, though, and I would think that it is difficult to put them in a nutshell, but, if I can summarise it in this way, when one practises as a consultant in a hospital, one practises as the head of a team and the different members of the team have duties in relation to the conduct of the individual care of the patients. It is teamwork. In private practice it is quite different. It is an individual service given to an individual person, at his own request. As an individual who practises both ways, I think there is a great deal of satisfaction to be had out of both ways of practising medicine, surgery and obstetrics. I think that the profession and the public lose if a man is practising his profession, in either of those two channels exclusively. That would be the way I would summarise the thing. There are many aspects of this problem.

4332. *Mr. Gunlake*: The preservation of a sector of private practice is something that concerns other professions, besides the medical profession. Would you agree that the preservation of an element of private practice is a very important means of retaining and preserving professional freedom?—I do, indeed.

4333. There is a danger that that freedom might ultimately be lost, if private

practice were ultimately to disappear?
—That is our belief, Sir.

4334. *Chairman*: In this particular field the doctor-patient relationship, which you are stressing, might very often apply to the general practitioner, who has dealt with the woman concerned right up to that moment, rather than the consultant whom she may not have seen very much. Are you implying that what you would like to see in the ordinary case is the general practitioner dealing with these cases in hospital?—I think there is room for both. I think we feel as a College that so far as private practice is concerned, as well as so far as the hospital service is concerned, there is a place for the consultant and there is a place for the general practitioner practising obstetrics, both in and out of hospital.—*Mr. Lewis*: As far as that is concerned, the abnormal obstetric patients choose to go to a consultant throughout the length of their pregnancy, and there you are likely to have the present doctor-patient relationship just as much with the consultant of their choosing, as with a general practitioner.

4335. I can quite see that in the abnormal cases, but the great majority of cases are not abnormal. You draw attention to the large number that are now going to hospitals, most of whom have, presumably, only been in contact with their general practitioner up to the moment.—Yes.

4336. So that if they go into hospital then, and they come under a consultant for the first time, from the purely psychological angle it does not make much difference whether it is a consultant allocated to them or one of their own choice?—Yes, that is so, Sir. We do mention the general practitioner obstetrician units which would be covered by that point.

Chairman: We will come to that later.

4337. *Sir Hugh Watson*: Can you give us any idea what proportion of births require the services of a consultant? *Mr. Lewis* mentioned the abnormal births. I suppose there are cases where consultants are called in, but there must be many thousands where a consultant is never called in.—*Mr. Peel*: It is a very difficult figure to give.—*Professor Claye*: I can tell you roughly what the state of affairs is in my own hospital. About 50 per cent of the patients who book are

normal and remain normal throughout, or have no very significant abnormality. Then there are about 25 per cent who are booked early in the pregnancy, because they are abnormal; the other 25 per cent develop an abnormality during pregnancy and are booked late, because they have developed that abnormality. I do not know if that helps you.

Sir Hugh Watson: That gives me an idea.

4338. *Chairman*: Is yours a general hospital, or is it a maternity hospital?—It is a maternity hospital.

4339. Probably, the proportion of purely normal ones would be higher, both in domiciliary births and in the hospital in general hospitals, would it?—Than in maternity hospitals?

4340. Yes.—Certainly, the lowest proportion of abnormal births, obviously, is in the domiciliary class, but I would have thought there was no great difference between the maternity units in general hospitals, and purely maternity hospitals.

4341. Allowing for the domiciliary ones, this rather suggests that something like two-thirds never have any abnormality, and something like one-third have an abnormality either early on or late, to a greater or lesser degree. Is that a right conclusion?—About half remain normal; one-quarter are early bookings, on account of abnormality...

4342. Yes, but since only about 60 per cent of all births are hospital ones, probably about two-thirds of all births are normal?—Yes. You are taking into account the domiciliaries.

4343. Yes.—*Mr. Peel*: May I just clarify one small point, and that is that the condition that you visualise of the normal obstetric patient being in contact with the general practitioner throughout the pregnancy, and then going into the hospital under the care of the consultant, does not frequently arise, because if a patient has elected to have a hospital birth privately, under a consultant, then the consultant looks after the patient throughout the pregnancy. If it is under the National Health Service, then they attend the ante-natal clinic of that particular consultant, and are not merely in contact with the general practitioner. The only case where there would be a change of person is if what is thought

to be normal becomes abnormal at a later stage; then there is a change of person responsible.

4344. Of the half of those who come to your hospital, who are completely normal from start to finish, most of them would not, in fact, require the care, at any stage of a full consultant? The delivery, for instance, would not require the attendance of the consulting gynaecologist?—*Professor Clave*: That is so, Sir.

4345. *Mr. Ganlake*: Still on your paragraph (vii), you refer to the question of full-time consultants and part-time consultants. This is a point on which we have had a good deal of evidence from other bodies. In the memorandum which was supplied to us by the Ministry of Health, which you may perhaps have seen, we are told that in the middle of 1956 there were 73 whole-time consultants in your specialty, and 391 part-time consultants, who were doing an average of about 8 sessions a week each. Would you care to comment on that picture? Is that about right in your view—the proportion between whole-timers and part-timers, and the average number of sessions—or do you feel that some changes ought to be made?—We have, of course, commented in paragraph (vii) about the desirability of consultants having a smaller number of sessions.

4346. May I take up that point? The average is 8 sessions a week. Included in that there will be people doing very few, so there must, obviously, be a number of people doing the maximum number of sessions. I gather from what you say that you feel there is too great a tendency for people to do too many sessions.—Yes, that was our case, Sir.

4347. *Chairman*: I was not absolutely clear on that. First of all, when you say that "a hospital is better served by two or more consultants with fewer sessions than by perhaps only one consultant with a maximum number of sessions", are you envisaging in the consultancy sphere something rather like a partnership in general practice?—Nothing as close as that, Sir.

4348. Not as close as that but, for instance, you rightly say that it is humanly impossible for one consultant to be constantly on duty day and night. In general practice there has been deliberately fostered an encouragement to

form partnerships so that the same man will not always be called out every night; there is a sharing of these kind of responsibilities. I was wondering whether you were envisaging anything of that nature in that sense.—No, we were envisaging merely that where one man was off, the other could do his work under a sort of gentlemen's agreement.

4349. That is rather the same sort of relationship. The second thing is that if the consultant has fewer sessions than the maximum because of this, what are you envisaging he does during the rest of his time—private practice?—That is the importance of the first paragraph, Sir. We hope that, if this alteration were made, a man would get more private practice and that would compensate him for his loss of sessions.

4350. But he will still be on duty for the same amount of time looking after his patients, if he has the same number, whether they are private or public will he not?—Yes, but there will be more of him, as it were. There will be two, for instance, instead of one, so that he will have a deputy when he goes off; whereas, at the moment there are quite a number of places where there is only one consultant, and if he goes off there is no consultant.

4351. *Sir David Hughes Parry*: I take it there are registrars, so there will be someone on duty for the normal type of case in a hospital, will there not?—Yes, but a registrar is not a consultant, Sir.

4352. But the registrar will deal with anything except a real emergency, will he not?—Yes, but surely the point about a consultant is that he has been appointed because he is capable of taking the maximum responsibility, and a man who is in a registrar post is not yet in that position. He has to refer difficulties to the person who is capable of taking responsibility, and that is the consultant.

4353. But if it is a straightforward case, he may not have to refer it to the consultant?—No. There are plenty of cases like that, of course.—*Mr. Malkin*: I think the worry is felt in a rather small town with a population of 50,000, which is too small to have more than one consultant, so if that consultant is away for holidays, illness, weekends, or something like that, he has got to get some

cover from the nearest town, which might be some distance away. Our view is that that is unsatisfactory, because of the possible emergency case. You could not encourage another consultant to come; he could not get a living as there is not enough hospital work, and he would not get enough remuneration if the sessions were divided down to four or so each. If it would be possible for each to do private practice to recoup on that, then we feel the hospital service would be better covered.

4354. *Chairman*: Supposing there are two consultants, each doing hospital work in 50,000 population towns, ten miles apart, for nine sessions, and suppose they so work it that they cover one another by each doing, say, four or five sessions in each of the two hospitals. Does that help you at all?—We thought it would. In practice it does not seem to have done so, because it has been tried. It means that one man would have to do all his obstetrics in one town, and the other man would have to do all his gynaecology away, because the distance might be too great to give adequate cover. It seems it is far more satisfactory to have two people intimately connected with one hospital, provided they can make a living, than to have them separated by a good distance.

4355. But they are still going to get the same number of patients in your town of 50,000 people?—Yes, but if there were more people able to pay private fees, which we think there would be if the cost of private accommodation were less, then the remuneration would be more or less the same.

4356. *Mr. Gunlake*: Is there, in fact, any other way by which the number of sessions could be reduced, other than by a greater volume of private practice? It is about the only solution we have had.—*Professor Claye*: Yes, we have not been able to think of one.—*Mr. Lewis*: The accent has been on the time the consultant is off duty. The position arises very frequently that he is busy doing a difficult operation on a case, and one of his obstetric cases starts to bleed. Under those circumstances, it is very useful, as we have found in London, where on the staffs of our hospitals we have several consultants, to be able to call in a colleague to cope with an emergency, while you are coping with another.

4357. *Chairman*: I can see that part quite clearly. I have not quite seen how the problem of the 50,000 population hospital is going to be greatly relieved, because I do not see how it is going to be able to employ at a satisfactory total remuneration two people, if it can only employ one now, even if they decide to have half their remuneration each from the hospital, and make it up by charging fees for the other half of the same number of births.—*Professor Claye*: We visualise that if the charges for private beds were not so exorbitant there would be a much better demand.

4358. Not more children born?—No.

4359. *Sir David Hughes Parry*: We now come to paragraph (viii) on the difficulties encountered by members of the registrar grades. In the second sentence there you say "With the limited number of consultant posts all registrars cannot hope to achieve consultant status. . . ." What registrar have you particularly in mind there? Is that all grades of registrars? I am not quite certain.—What I think we are visualising there is promotion from senior registrar to consultant.

4360. You say "With the limited number of consultant posts all registrars cannot hope to achieve consultant status. . . ." If that is so, there will be some who obviously, for some reason or other, will not be consultants. What suggestion have you to make about them, as regards their remuneration?—You know you are asking a very difficult one there, Sir.

4361. It is one of the great problems that we have to face, and we are asking you to help us.—Some of them, of course, go abroad, some of them take up academic posts, and I think some manage to get into some other branch. It is very difficult for them to get into general practice at that stage, as you know. It is much easier to get into general practice with the absolute minimum of hospital experience.

4362. We will come back to that in a moment. How would you react to the suggestion, which has been made to us, that a certain number of these people might be continued in salaried posts in hospitals for good, or until such time as they were appointed consultants?—We are against a sub-consultant grade, Sir, in addition to what we already have.

There is the Senior Hospital Medical Officer, whom we were led to suppose would be a temporary grade, but he is still persisting. We have already got one sub-consultant grade, and we do not want another.

4363. How many people are really involved in this? What sort of number is it?—I wonder if Mr. Lewis would answer that. He is the man who can speak about the figures for senior registrars.—*Mr. Lewis*: It is extremely difficult to say how many are involved, but one can go by the number of applicants there are for various consultant posts which come up at the present time, and for an attractive post you can say there are between 30 and 50 applicants for each single appointment.

4364. They will all be senior registrars?—They will all be senior registrars, Sir. Some of them will be not completely fully trained, and they are trying to get known early; others are well beyond the five years of senior registrar, which would be regarded as the sort of time a man should do before he is fully trained, and some of them will have had just about the right amount of training.

4365. They will be from, presumably, the second, third and fourth years?—Yes, the second, third and on up to the sixth, seventh or eighth, perhaps. My present registrar is aged 36, and he qualified when he was 23. He is fully qualified. He has got every diploma, and he is among the 50 or so who have been putting in for the jobs. He has been short-listed for three out of the last seven applications that he has made. That is the typical sort of set-up at the moment.

4366. How many vacancies a year are there?—From the Ministry figures we are told that in 1963 and on for the next 11 years, there will be roughly 20; at the moment it is a few less, say 15 a year, but it will go up to 20. It depends on the ages of the consultants who are actually consultants at the moment.

4367. *Chairman*: I was just looking again at the evidence that you submitted to the Willink Committee, which is attached to this memorandum. That seemed to me to show that there was not a very large difference between the number . . .—Between the number that we are training and the number that we want? That is absolutely true. The

difficulty is this pool of 50 fully trained men, who are now ready to go into an appointment.

4368. And I think you say you expect normally to have about 20 vacancies in consultancy a year.—Yes.

4369. The mere fact that 50 people apply for one job, does not necessarily make it very bad. It depends how often a job comes up, but you say it comes up about 20 times a year?—Yes. If all those who were now ready to go into consultant posts, and had done five years and onwards, got consultant posts, the position would be solved.

Sir David Hughes Parry: Would it? On page 914 it says that there are 36 in training, for whom there are only going to be 20 posts.

4370. *Chairman*: You get a wastage, do you not?—That becomes less if you follow on. We suggest that there should be 25 in the first year, and for each subsequent year.

4371. I was not even sure about that. You are suggesting that each one will do five years?—Yes.

4372. But none of them will get a consultancy until they have done five years?—That is the average.

4373. Not the average, but each one?—Yes.

4374. *Sir David Hughes Parry*: I do not think there are any further questions on the senior registrar, so I am going to ask a question on the junior registrar.—*Mr. Makin*: Could I just mention one point? You were asking how we were proposing to deal with these senior registrars. It does follow on that, if it were possible to have more consultants by having a continuation or extension of private practice, it would obviously be possible to absorb quite a number of the present senior registrars.

4375. *Chairman*: In this evidence to the Willink Committee, you said that the total number of consultants and S.H.M.O.s was 580, and that when you had 90 per cent. of births in hospital you then thought a total number of 600 consultants would be needed.—Yes, Sir, and I think that is based on maximum part-time. That is not based on sessions.—*Mr. Peel*: It is rather based on the situation as it is at present. If the situation changed, and there were more consultants doing less sessions, then

there would be a larger number of consultants required.—*Mr. Lewis*: Are you concerned with the jump from 580 to 600?

4376. No. I was meaning that it is not really a very large jump. I know the 580 includes the S.H.M.O.s.—Yes, Sir, and that jump included the required increases in establishment, which the various Governors' Boards and Regional Boards said they required.

4377. The total number was 580 in 1955, and is now how much?—We have no further figures.—*Mr. Malkin*: Those are based on present conditions, of course.

4378. *Sir David Hughes Parry*: May we take the position of the registrars, without the word "senior" before them? How many do you propose that there should be? You suggest on page 916, I think, that there should be 240. Is that right?—*Mr. Lewis*: A total number of 240. They are appointed for two years, so it would be half that number appointed each year.

4379. And you envisage that 120 of them would become senior registrars. What would happen to the other 120? I am concerned with them.—We thought that in the gradual training of an obstetrician there would be a point in his career when he could either go on or turn back, and we thought that that point was between registrar and senior registrar. We thought it was fair to train a man for two years, and at the end of that time to tell him that he was unsuitable, and that he would have to go in for another branch of medicine.

4380. *Chairman*: We have, in fact, to visualise promotion for only one in five of your registrars?—Yes. There are 125 registrars appointed each year for two years, at the end of which time of those 125 only 25 each year will become senior registrars. So one in five of the registrars will become senior registrars, and the other four have to do something else. Perhaps they go into general practice and do obstetrics in general practice. They will be well qualified to do so.

4381. *Chairman*: Do you anticipate or find at present that there is much difficulty about four out of five, for instance, of your registrars getting back

into general practice then?—Not at that stage, Sir, no.

Chairman: At that stage transfer is reasonably easy?

4382. *Sir David Hughes Parry*: It is probably easier in this specialty than in some others?—I would say that it was probably easiest for a man doing general medicine to go into general practice from the registrar level. But I do not think it is very difficult for a man doing obstetrics.

4383. I had an impression that a general practitioner was more ready to have a partner who had some qualifications here, with a view to relieving the older partner.—From his obstetrics?

4384. Yes.—Yes, I think that is true.

4385. *Chairman*: You would like the senior registrar, then, to have been quite carefully selected, to have been through a careful process of selection at the transition from registrar to senior registrar, and some selection when he became a consultant? You do not want a guarantee that the senior registrar will be a consultant? You want to retain the competitive element, but you want him to have a very good chance? Is that right?—That is so, Sir. I think that the selection is at the appointment to senior registrar. We have suggested the training of 25 senior registrars for 20 consultant posts. We do not consider that the 5 or so, who do not get consultant posts, will go into general practice. We think that, perhaps, they will go abroad or do obstetrics somewhere else.

4386. You would still expect, I suppose, that some of them would have to wait a bit longer?—Yes.

4387. There will always be some overlap. Do you envisage some measure of security for senior registrars in the way of being put on the establishment at approved rates of salary, where they are what you might call time-expired?—I think that is so, Sir, so long as we are not faced with having in our hospitals men who are of consultant status who are permanently paid at senior registrar level, which is what we are very much against.

4388. By consultant status you mean taking the full ultimate responsibility, do you?—I mean a man fully trained in

a junior position. That is, we do not want permanent senior registrars in our hospitals as a permanent thing. I think if we were allowed to prolong a man's appointment for, say one or two years over the average time, the five years, that would help.

4389. *Sir David Hughes Parry*: But it would not absorb all: some would be turned away?—We try to fix this figure of 25 being trained each year to absorb all. If we felt that was too many we might have to say 22 or 23. That was our aim in arriving at this figure; we felt all ought to be absorbed in some way.

4390. You do make the suggestion on page 912, that they be given part-time employment in the hospital service as clinical assistants. That is a temporary measure?—These are the two-year registrars, I think.

4391. These are the two-year registrars.—They go into general practice. Four out of five go in, and because they have done these two years might perhaps be given some obstetric appointment in a general practitioner unit or even in a hospital.—*Mr. Peel*: We think that this certain percentage of these men who have done a period as a registrar would be very suitable people to be general practitioner obstetricians. If given appointments as clinical assistants in some of the hospitals, not necessarily the big regional hospitals but certainly in general practitioner hospitals and provincial hospitals, they might well contribute towards reducing the total number of registrars required and help to relieve the situation.

There is one other point I want to make in regard to the registrar, particularly apropos our being a Commonwealth College: there are a considerable number of registrar posts which are filled by men from overseas at the present time. In fact they are a very important contribution to maintaining the number of registrars because the registrar post in our subject in many hospitals throughout the country is becoming an unattractive one and it is very difficult to get men to apply for registrar posts.

4392. *Chairman*: Is there a difference in this respect between teaching and peripheral hospitals?—I think that is so, yes.

4393. Have you any suggestions about how to make those equally attractive?—I think the only way you can ever make it attractive is by making it no longer a dead end job. If becoming a registrar for two years means at the end of that time there is nothing for him to do in that particular field, it is no longer an attractive post; and if such a man could go into general practice with a good experience of obstetrics and feel that he can make a useful contribution, it would be an outlet for a considerable number of registrars.

4394. It was put to us that very often the experience that you got in a peripheral hospital in this country was perhaps better than in a teaching hospital, was of a more general nature; the registrar was more apt to take decisions himself?—Yes, I think there is more practical experience with less controlled training if I can put it that way.

4395. I was thinking in terms of becoming a general practitioner to a registrar who remained a registrar with a view to becoming one of your four out of five.—Yes, it is a very excellent training for him.

4396. At the same time it is difficult to get these registrar appointments filled in the non-teaching hospitals on the periphery?—That is so, yes.

4397. There is no difficulty in the big teaching hospitals?—That is so, yes.

Sir David Hughes Parry: Your paragraph (x); I think we know now the great importance which you attach to private consulting practice as an incentive and really for the good both of the National Health Service and of the consultant himself. I think we have that point. I do not know that we need pursue it any further. Then the comparative treatment for income tax purposes, that again I think we have fully gone into with other bodies.

4398. *Chairman*: This fee of seven guineas to which you refer in paragraph (xiii) Professor Claye, that can cover a rather wide range of attention, can it?—*Professor Claye*: Yes, Sir.

4399. The seven guineas can be earned for rather little or a great deal?—Yes, it is the normal fee for a patient who

books a general practitioner and goes right through.

4400. But the work required to earn the fee varies in extent?—It may or may not very much. As you know, the Ministry lay down a certain minimum of attention which is very much below what is the optimum. A man may do very little for his fee or he may, if he is a conscientious man or if the patient turns out to have trouble of one kind or another, get a very great deal more.

4401. This may be affected by the nature of the case?—Yes, Sir.

4402. But it may also be affected by the inclinations of the doctor?—That is the point.

4403. To the extent that it is the latter, would you feel it rather encourages the doctor with an overloaded list to do less?—Certainly it does not discourage him.

4404. Have you any suggestions about that particular point? Would you like to comment further on it?—I do not think I would, Sir. This is really a purely general practitioner point. I do not think it is up to us to comment on it.

4405. We are always looking for opportunities for seeing how to reward good doctoring in general practice rather than simply taking the capitation fee method. I wondered whether you had anything to suggest on that at all?—I do not think I have anything to say.—*Mr. Peel*: The only thing one might say in general, Sir, would be that in general practice, going back to this same old question that only a limited number of general practitioners really want to do obstetrics and are experienced to do it; we feel the better paid they are for that service the more they will be able to reduce their other commitments and the better service they will give in obstetrics to their patients. That is the general belief and I think it would be true. If better rewarded for that particular service they could cut off some of their other commitments with regard to capitation fees and the public would get better service from the doctor for obstetrics.

4406. *Sir David Hughes Parry*: I see what you say on the question of merit awards and the method of allotting them. We are aware of the criticisms,

but I think you make none yourself?

—*Professor Claye*: Yes. The Chairman, Sir, at the beginning I think said if we wished to modify our opinion at all we could do so and I think that we have been unnecessarily lukewarm in our remarks about the merit award system. I think we do all want it. I myself have been a member of the Merit Awards Committee for the last few years. I cannot myself imagine any fairer way of recognising merit than this award. It is done with tremendous care and I cannot visualise a better way of doing it.

4407. Yesterday the Surgeons emphasised the fact that it was really a method of securing differences in remuneration. I notice in the way you present it today you indicate that it is a method of recognising merit.—Surely it can do both, can it not, Sir?

4408. I do not know.—I would have thought so.

4409. One wonders you see. It really was decided as a method of preserving differences in remuneration that was earned before 1948, was it not?—Yes.

4410. That was the object of it, was it not?—Yes.

4411. One wonders whether the word "merit" or "distinction" is not a part of the trouble in the minds of those who are critical of the awards and the method of awarding. Any observations on that?—I am not quite sure what you are getting at, Sir.

4412. I am sorry. You see the person who gets a merit award gets a better form of remuneration, does he not? Is it a question of paying a bigger salary or remuneration, or is it really a question of giving a merit award as such?

Chairman: You see, there are many more consultants now than there were at the beginning of the service. Of all specialties taken together therefore the number of people who get a merit award are far more than envisaged by Professor Bradford Hill who made his investigation of consultants' earnings at the beginning. It may be that the percentage of one-third at any one time of all consultants being meritorious may not be just the right conception. On the other

hand it may be right, that one-third of all consultants should at all times be getting rather more than the basic consultant amount as a means of increasing their payment. I think that is putting it another way.—*Mr. Malkin*: Would not that imply, Sir, if it were just a means of remuneration that it would be automatic, giving security, whereas at the moment it is not? It is obvious security must be taken into consideration. I take it we would not have somebody on the top grade. There must be the additional standing for them, to recognise the work they have done; so I would say it was rightly called a merit award.

4413. But *Mr. Malkin* it is given to one-third of all consultants now whatever the number of consultants may be. That is right?—Yes, but then the standard of merit necessary must vary in an increased number of consultants.—*Mr. Peel*: Then surely the fact there are three grades of merit awards makes it rather more sense, does it not? At first sight one-third does seem a high percentage, but the fact there are three different grades of merit award, the lowest of which is not very different—I think only about a 20 per cent. addition to salary—makes more sense of the system. Essentially surely it is a method of maintaining the differential amongst consultants so that outstanding work and merit may receive additional remuneration and additional remuneration not merely to go on with but to provide security for a particular position.

4414. *Sir Hugh Watson*: Would you say, Professor Claye, so far as you know that the principles by which the allocation of these awards is governed are well known to all the people who are eligible for them?—*Professor Claye*: It has been well publicised in the British Medical Journal.

4415. Yes, but we had Lord Moran before us who told us how he did it. In his own mind he was quite satisfied that he and his committee had done everything that was possible to make sure that the claim of every consultant who was eligible for a merit award was considered and every consultant knew that. I gather you are one of Lord Moran's colleagues. Would you agree that is the position?—Yes. I think there is very little excuse for any consultant not knowing that.

4416. *Chairman*: Professor Claye, in your memorandum to the Willink Committee, you said:

"In accordance with the opinion of the Council of the College that the posts at present filled by S.H.M.O.s should in fact be filled by consultants, the two appointments have been considered together."

In fact, in the total there are about, in round figures, 7,000 consultants and 2,600 S.H.M.O.s at present not gynaecologists in the total range of specialists. Now if your recommendation to the Willink Committee applied throughout that would add 2,600 people to the total consultant establishment. Would you think that made 900 more people, one-third of that number, deserving of merit awards?—*Mr. Malkin*: That was only recommended in respect of our specialty.

4417. You are only dealing with your own specialty?—*Professor Claye*: On the face of it I think the answer to your question is no, Sir.

4418. It would need some modification to take account of it?—Yes.

4419. *Sir David Hughes Parry*: That is all I have to ask, Sir, I think. Is there anything further you would like to add? Would you like to raise any matter I have not raised?—*Mr. Peel*: There is just one that occurs to me, going back to the very first page of our memorandum and I think your very first question, dealing with the amount of emergency work. I think one might express it in this way, that in some specialties the rate of emergency work is very low, but in obstetrics the birth of babies either normal or abnormal is evenly distributed round the 24 hours of the clock. Therefore inevitably there must be a great deal more night work and emergency work in obstetrics than practically anything else except perhaps emergency surgery. That was the point we wanted to emphasise I think so far as the remuneration side was concerned. We did feel there should be some method of recognising emergency work for those who practise in obstetrics.

4420. Does that mean a difference in remuneration for consultants?—No, merely a recognition of the kind of emergency work done by that particular individual.—*Professor Claye*: If I may say so, Sir, when the consultant makes

out the work he does for his contract he is supposed to include a figure for his emergency work. This paragraph I believe applies solely to general practitioners. The consultant in making out his figures should allow for an amount of emergency work he is likely to get.

4421. *Sir Hugh Watson*: Making out what figures?—When we originally got our contract we were required to estimate the dimes we put in on the various parts of our work.—*Mr Peel*: I think we were meaning it as a continuation of that principle, that some recognition should be made.

4422. *Chairman*: There is just one point I would like to take arising out of that, Professor Claye. It is on the question of what you might call constructive work because I would suppose that in this field there is much scope for the general practitioner or the consultant to do a good deal of educational work in clinics—in the "Well Baby Clinics"—not a very euphonious term. If it is done by a whole-time consultant that is in part of his contract, but if done by the general practitioner presumably at the expense of some patients on his books. Have you any views as to the extent of this?—*Professor Claye*: I do not think we are well informed about the position of general practitioners with regard to that, Sir.

4423. Do you think there is scope?—There is certainly scope.

4424. Do you think it should be encouraged?—Yes.

4425. Is that one of the things that among general practitioners really should in some way be recognised as good doctoring, to get a reward?—The word "merit" is getting a connotation—good doctoring, yes.

4426. Because we are anxious to find ways of helping good doctoring that is not solely related to the number of heads.—I certainly think that sort of work should be encouraged.

4427. *Sir Hugh Watson*: It was suggested to us the ideal doctor would be the one with a full list and an empty surgery.—Yes, Sir.

4428. *Chairman*: I do not think we have any more questions. You have made some comments in your last paragraph that are rather parallel to some that others have made and have a bearing on the Coleraine Committee, and it is for that reason we have discussed it with others. I do not think we need to question you further on that.—*Mr. Lewis*: This question of our increasing the time required for our diploma of Membership of the College: it was suggested by increasing it from three to five years we might increase the cost of training a man. In fact, that would not be so because if at the moment he took it after three years, he would take it during his second year as senior registrar. By increasing it by two years, he would take it in his fourth year as senior registrar. He would not be eligible to be a consultant until the fifth year. So merely giving him a diploma at a later stage would not alter the duration of his training or the cost of it. It would be merely giving his diploma at a later stage.

4429. *Sir David Hughes Parry*: Part of the training, indeed most of the training, is practical, but there are some lectures and courses, are there?—Yes, Sir.

4430. And study and reading?—And at one stage of his career he has to take his diploma.

4431. But the study, presumably he pays fees for the lectures, does he?—If he attends a course; he does not have to attend a course.—*Mr. Malkin*: Usually just one course.

4432. It is lengthening the period of practical training?—Yes. The diploma would be the same. It would be the length of practical training.

4433. I should have thought also there was a parallel course which also would be lengthened?—No. He is working all the time.—*Professor Claye*: Mr. Lewis mentioned five years. As we are being reported I would like to make it quite clear there is no question of our increasing the time of training to five years at present.

4434. *Chairman*: We were talking rather in terms of your evidence to the Willink Committee three years ago. That

was really what gave rise to this. Was that evidence public, do you know? I imagine it was.—I think it was, Sir.

4435. You keep on talking about "his" and "him". Just as a matter of interest—I do not think you told us anywhere—is this branch of the profession one which has a particular attraction for women more than men?—It is.

4436. What proportion of the Fellows of your College are women?—I ought

to be able to answer that but I cannot. I am afraid I do not know. If you would like the figures we can certainly get them without any difficulty.

4437. I asked rather as a matter of interest than anything else. I think if you have no other points to raise that concludes the session. Thank you very much. It has been a very interesting and a very useful session.—Thank you, Sir.

(The witnesses withdrew)



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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

18

Eighteenth Day, Thursday, 8th May, 1958

WITNESSES

Society of Medical Officers of Health
Society of Medical Officers of Health
(Scottish Branch)

Association of County Medical Officers
of Health of England and Wales

LONDON

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration EIGHTEENTH DAY

Thursday, 8th May, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MR. A. D. BONHAM-CARTER, T.D.

SIR DAVID HUGHES PARRY, Q.C.

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

SIR HUGH WATSON, D.K.S.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

Explanatory Note by the Royal Commission

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence, to all representative medical organisations:—

- (i) The quality and quantity of recruits (a) offering themselves and (b) accepted for training as medical students.
- (ii) The quantity and quality of newly qualified doctors.
- (iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.
- (iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).
- (v) The position and prospects of a newly qualified doctor.
- (vi) Any trend to excessive resort to certain branches of the profession at the cost of others.
- (vii) The relative advantages and disadvantages, financial and otherwise, of service as:—
 - (a) a principal in single-handed general practice,
 - (b) a partner in general practice,
 - (c) a whole-time consultant in the National Health Service,
 - (d) a part-time consultant with the maximum number of sessions,
 - (e) a part-time consultant with only a few sessions,
 - (f) a Senior Hospital Medical Officer,
 - (g) a doctor in any other sort of practice or employment.
- (viii) The difficulties encountered by members of the registrar grades.
- (ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.

- (x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.
- (xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.
- (xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service.
- (xiii) Any anomalies in the methods of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume.
- (xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.
- (xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.
- (xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.
- (xvii) Special considerations of which account ought to be taken in discussions of medical remuneration.
- (xviii) Specific proposals for medical remuneration.
- (xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.
- (xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.
- (xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

THE SOCIETY OF MEDICAL OFFICERS OF HEALTH

Memorandum of evidence submitted by the Society of Medical Officers of Health to the Royal Commission on Doctors' and Dentists' Remuneration.

1. This evidence is submitted as the result of a direct request contained in a letter dated 11th June, 1957, from the Secretary of the Royal Commission on Doctors' and Dentists' Remuneration; a request which the Society feels it is its bounden duty to comply with, although it must be clearly understood that it is a scientific body and not itself directly concerned with terms and conditions of service of its members. The Society is, of course, very conscious of the fact that a stage may be reached in any group of persons when the absence of financial incentive may seriously affect recruitment to and the efficiency of the particular service.

2. The Society of Medical Officers of Health was founded in 1856. The membership was originally restricted to medical officers of health, but the constitution was widened over the years so that it now includes public health medical and dental officers in the employ of local authorities, in the Ministries of Health, Education, Housing and Local Government, Labour and National Service, Pensions and National Insurance, in hospitals, universities, laboratories, the Armed Forces, and Her Majesty's Overseas Civil Service.

3. The membership of the Society is now over 2,300 of which two fifths are deputy medical officers of health, senior medical officers and medical officers employed in departments, just under one quarter medical officers of health, one tenth retired, about one sixteenth medical officers belonging to the hospital service, including chest physicians, and roughly the same proportion of dental officers; the balance comprising civil service medical officers (including those in the public health laboratory service), members of the Forces and those serving overseas, those engaged in academic duties, and others.

4. The latest available figure for public health medical officers in the United Kingdom, exclusive of Northern Ireland, is 2,490.

5. The Society, therefore, being the largest representative body of public health medical and dental officers in the United Kingdom, is well able to speak for the profession on matters connected with the work of those branches of medicine and dentistry.

6. Since the British Dental Association is a negotiating body and giving evidence in connexion with dental officers, it has been thought advisable to reserve comments chiefly to medical officers rather than to impinge on the dental side.

7. There is a general agreement with the observation contained in the letter from the Commission of 11th June inviting the Society's views that the majority of the topics included in the list accompanying the letter in question are outside the specialised field of interests of public health medical officers. For this reason, it is proposed to offer comments on a proportion only of the topics referred to in the preceding sentence.

8. (v) "*The position and prospects of a newly qualified doctor.*"

Though a career in the public health service has its very real satisfactions, these differ in a nature from those of the doctor engaged in curative medicine. In place of the traditional personal doctor-patient relationship, he is, for much of his time, concerned with the community, rather than with the individual. Since his undergraduate training has laid its greatest stress on individual relationships in curative work, the young doctor who enters public health must have a special interest amounting to a definite sense of vocation.

9. The medical officer of health is the only doctor who is by *statute* required to hold a higher degree or diploma. It follows that every doctor who intends to make a career in public health will have to obtain a diploma in public health or its equivalent as early in his career as possible, in addition to any other non-statutory higher qualifications which may be of value to him. But while the doctor in clinical practice who is seeking non-statutory higher qualifications can proceed to them while he is actually working in a whole-time appointment at an appropriate salary, the doctor in the public health service, seeking the statutory D.P.H., has rarely such opportunity. He is commonly required to undertake a whole-time course lasting for a full academic year and it is most exceptional for an employing authority to pay even a token salary to an officer while he is taking such a course. In a limited number of centres it is possible for a doctor to take a part-time course for the D.P.H. and to do part-time salaried work, but in such cases the period of the course will be proportionately extended beyond one academic year, while the remuneration for the part-time work is unlikely to exceed about £600 per annum and will not be adequate to maintain a doctor who, being several years qualified, is likely to be married and to have a family.

10. The rates of remuneration for members of the public health medical service, are, in many cases, so inferior that some posts are advertised again and again over long periods without attracting suitable applicants.

The following table compares the rates of salaries in 1950 and 1957 for public health medical officers.

	<i>Rates of salary*</i> <i>Industrial Court Award,</i> <i>1950</i>	<i>M.D.C. No. 27†</i> <i>1956</i>
Medical officers employed in departments	£850 to £1,150 by £50	£1,050 by £50 to £1,200 by £55 to £1,475.
Senior medical officers ...	£1,250 to £1,650 by £50	£1,520 by £50 to £1,570 by £55 to £1,955.

* The Industrial Court (2285) Public Health Service, 8th December, 1950.

† Whitley Council for the Health Services (Great Britain). Medical Council: Committee C. 4th June, 1956.

Medical officers of health. Local authority population not exceeding				<i>Minimum of salary scale Between</i>	
75,000	...	...	...	£1,450—£1,650 4 increments of £50	£1,740—£1,955 4 by £55 increments
100,000	...	...	...	£1,550—£1,850 5 increments of £50	£1,850—£2,175 4 by £55 & 1 by £50 increments
150,000	...	...	...	£1,750—£2,050 5 increments of £50	£2,070—£2,395 4 by £55 & 1 by £50 increments
250,000	...	...	...	£1,950—£2,250 2 increments of £100 1 increment of £50	£2,290—£2,605 2 by £105 & 1 by £55 increments
400,000	...	...	...	£2,200—£2,500 2 increments of £100 1 increment of £50	£2,500—£2,865 2 by £105 & 1 by £55 increments
600,000	...	...	...	£2,300—£2,700 3 increments of £100	£2,655—£3,075 3 by £105 increments
Over 600,000	...	...	...	At discretion	At discretion

In comparing salaries of doctors in the public health service with other doctors, it is important to consider not only the average maximum salary, but also the chances a doctor entering the service has of reaching a salary of, say, £2,000 per annum.

In evidence given to the Industrial Court in 1950, it was shown that about 90 per cent of public health service doctors received incomes of less than £2,000; on the other hand, approximate percentages were in the order of 42 for general practitioners, 45 for senior hospital medical staff and 55 for industrial medical officers.

Minor cost of living adjustments since that date will have reduced the figure of 90 per cent nearer to 85 per cent but they have not substantially affected this ratio. On the other hand, there have been general increases in other branches of the profession; but the relationship shown by the 1950 figures remains essentially the same.

11. (vi) *"Trend to excessive resort to certain branches of the profession at cost of others".*

The financial and other attractions of the clinical side of the medical (and dental) profession result in the large proportion of young doctors and dentists opting for the hospital service or private practice. A consultant post in which the holder may qualify for a merit award, with, perhaps, 9/11th contract with a Regional Hospital Board or Board of Governors, is manifestly a great attraction to a young man.

12. The fact that substantial allowances in relation to income-tax for expenses of part-time consultants and general practitioners are obtainable under Schedule D, makes their financial conditions much more attractive than those of public health medical officers under Schedule E.

13. The very real difficulty experienced at the present time in recruiting anything like enough, in quality as well as in quantity, of public health medical officers under the existing unfavourable conditions of salary, promotion, etc., is exercising a profound effect in the preventive field at a critical time. The results of hard campaigns against tuberculosis and the acute infectious fevers are bearing fruit, and much is waiting to be done to improve domiciliary service to the handicapped and the old and in the prevention and cure of mental breakdown responsible for filling nearly half the number of hospital beds available for all purposes under the National Health Service.

14. (xii) "*Comparative treatment for Income-Tax purposes, etc.*"

The Society does not propose to offer any comments on this topic at this juncture. Nevertheless, it is particularly interested in securing an increase in the number of appointments of public health medical officers as consultants in preventive medicine to hospitals, which although not affecting many officers in the field of social and preventive medicine at the present, is, the Society hopes, likely to do so in the near future. Reference has been made earlier to the discrimination affecting public health medical officers on the subject of income-tax allowances, expenses of membership of learned societies, and so on.

15. (xv) "*General comments on the system of merit awards and the method of allotting them with any suggestions for an alternative system.*"

The Society does not wish to comment on the system except to say that whatever system is used for the recognition of merit or distinction should be applicable to all branches of medicine including preventive medicine. At present there are no medical officers of health receiving salaries equal to those of consultants with the top award.

16. (xvi) "*Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets* of practitioners.*"

The present scales of salaries for assistant public health medical and dental officers and for many medical officers who have dependents to care for result in these officers having to accept a lower standard of living for their families and themselves than it is right to expect of professional people who have spent at least eight years in qualifying and obtaining a diploma in public health and, possibly, in acquiring other higher medical qualifications and a diploma in child health, industrial health, bacteriology, etc.

17. (xx) "*Proposals for specific machinery or procedure to be established for dealing with future discussions of medical remuneration.*"

The salaries of public health medical and dental officers should not be related in any way to those of non-medical officers employed by local authorities.

18. The Society claims that its members, as members also of the medical profession, should have the same right of direct negotiation and appeal to arbitration without restrictions, which should be enjoyed by all members of the medical profession.

19. As was stated in the opening paragraphs of this submission, the Society is a purely scientific body, and, therefore, not designed for direct negotiation on financial matters.

20. The Society desires to emphasise very strongly that the findings of the industrial courts have been arrived at entirely in relation to salaries paid to the lay-officers of local authorities. It is a matter of deep concern to the Society that the claim of doctors in the public health service to be treated as members of the medical profession and to be paid on that basis has been, up to the present, completely ignored.

21. Members of the public health service are at a special disadvantage with regard to superannuation benefits. Non-medical local government officers commonly join at a much younger age than is possible for medical officers. The former make small superannuation contributions for their earlier years, yet their pensions may be greater than those of medical officers. The payment of additional contributions for added years, which nearly all public health medical officers have to consider in order to increase the amount of their pensions, is a particular hardship.

A case may be cited of a medical officer of health who must contribute £250 a year in order to obtain the advantage of five added years.

* See appendix.

22. Lastly, the Society feels very strongly that medical officers of health should be regarded as consultants in social and preventive medicine (as recommended by the Guillebaud Committee* and supported by the Central Consultants and Specialists Committee and Council of the British Medical Association); and it is only just that their remuneration should be related to that of consultants in curative medicine. Medical officers in the public health service, whether medical officers of health or engaged in some special branch of preventive medicine (e.g., in maternity and child welfare or as school medical officers) should receive increased remuneration commensurate with higher responsibilities or distinction.

The salaries of medical officers of health should not be less than the minimum salaries of consultants and the ceiling should not be less than the maximum salaries of consultants inclusive of merit awards.

C. METCALFE BROWN,
Chairman of Council.

H. D. CHALKE,
Chairman of Executive Committee.

SELWYN SELWYN-CLARKE,
Secretary.

The Society of Medical Officers of Health.
Tavistock House South,
Tavistock Square,
London, W.C.1.
24th October, 1957.

* Reports of the Committee of Inquiry into the cost of the National Health Service (Cmd. 9663) paras. 714 and 715.

THE SOCIETY OF MEDICAL OFFICERS OF HEALTH

Budget for 1.3.56 to 28.2.57—Medical Officer*, County Council and part-time M.O.
borough

	£	s.	d.	£	s.	d.
<i>Income:</i>						
Gross salary				1,531	19	9
Family allowances (8s. for part of year & 18s. for part of year) ...				30	6	0
Testamentary gift				113	2	2
Legacy (part)				401	0	0
				<u>£2,076</u>	<u>7</u>	<u>11†</u>
<i>Deductions:</i>						
Superannuation	91	18	4			
N.H.I.	17	11	0			
Income Tax	237	10	0			
	<u>£346</u>	<u>19</u>	<u>4</u>			
Net salary, etc.				1,729	8	7
<i>Expenditure:</i>						
Housekeeping				396	7	6
Housing:						
House purchase policy	202	10	0			
Rates (including water rate)	70	8	2			
Schedule "A" Tax	26	9	1			
Insurance	68	11	5			
Education policies (2)	106	15	7			
Repairs and replacements	52	14	5			
Furniture and furnishings	94	2	8			
				<u>£621</u>	<u>11</u>	<u>4</u>
<i>Car:</i>						
Tax	12	10	0			
Insurance	21	0	0			
Repairs	42	12	5			
Car hire purchase	164	2	0			
Petrol and oil	71	0	0			
				<u>£311</u>	<u>4</u>	<u>5</u>
Fuel and light				78	2	8
Telephone				30	0	0
Holidays				45	11	6
Subscriptions to learned societies, etc.				14	14	0
Personal expenditure (new baby, etc.)				231	17	2
				<u>£1,729</u>	<u>8</u>	<u>7</u>
Total expenditure						

* Aged 34 years; qualified 1948; holds D.P.H. and D.C.H.; wife and three children born 1952, 1954 and 1956; entered public health service in 1954.

† Mileage allowance is not included because this is absorbed by use of car on duty.

air pollution, potential nuisances, and so forth, but his duties have now become enlarged into something different—something bigger. His main work nowadays is to study all factors affecting the health of the community, and—without neglecting the remaining infectious diseases—to apply to other health problems the epidemiological and other methods which yielded such striking results in reducing infections."

5. The National Health Service Acts laid fresh emphasis on the local health authority as the body primarily concerned with the prevention of sickness and the promotion of healthy living. The medical officer of health, *the only medical specialist in whose case a post-graduate qualification is obligatory by law*, must study all factors detrimental to health, must act as expert adviser to the local health authority, and must deploy and direct a considerable number of professional staff—departmental medical officers, health visitors, public health inspectors, domiciliary midwives, etc. His tasks range from devising ways of reducing still-births to developing measures to maintain the physical and emotional health of old people, and from the prevention of infections to the prevention of broken homes.

6. Since no further reference is made in this memorandum to the non-medical professional workers in the Health Department, it is perhaps appropriate to indicate that, even in a small population unit, a medical officer of health acts as director of a considerable professional staff: for instance, in a small county borough of 75,000 population his staff might include—5 medical officers (considered below), 3 dental officers (professional officers with five years training), 19 health visitors (professional officers with 4½–5 years training), 4 midwives (with 4 years professional training), 14 district nurses (with 3½ years professional training), 8 public health inspectors (with 3 years training), 1 physiotherapist (with 3 years training), 1 audiometrist (with 2 years training), etc., to say nothing of a large number of less trained staff (e.g. 60 home helps).

7. The Medical Officer of Health is, therefore, even in the smallest population units, a doctor who has taken a post-graduate qualification (requiring one academic year of full-time study), who has passed through various junior grades in his profession, and who has duties and responsibilities comparable with those of clinical consultants. The same is true of the Deputy M.O.H. in population units large enough to have such an officer, while the M.O.H. of a large population unit—having progressed by merit from the post of Deputy in such a unit or of M.O.H. of a smaller unit—is entitled to be compared with a consultant with a merit award.

8. While the M.O.H. of a large population unit is fully comparable with a consultant with a merit award, and while the M.O.H. of a population unit of 100,000 or above is fully comparable with an ordinary consultant, there are certain difficulties in respect of the comparability of M.O.s.H. of small population units. For instance, a public health specialist in charge of the health services of a town of 50,000 population may spend $\frac{1}{2}$ of his time doing the work of a medical officer of health and the other $\frac{1}{2}$ doing work that in a larger unit would be undertaken by a departmental medical officer. In any comparison it would be fair to regard such an individual as equivalent to a consultant for six sessions weekly and to a senior hospital medical officer for five sessions.

(b) Senior Medical Officers

9. Population units of above 250,000 generally have a grade of senior medical officer in charge of large sections of work. For example, the medical staff of a county of 300,000 population might comprise—

1 M.O.H.

1 Deputy M.O.H.

3 Senior M.O.s. (in charge respectively of Ante-natal and Child Welfare work; the School Health Service; and the Health of the Elderly and the Handicapped).

16 Departmental M.O.s.

10. The senior medical officer, after having taken a post-graduate qualification (requiring, as mentioned, one academic year of full-time study) and after having gained experience as a departmental medical officer, has shown particular ability in one branch of the public health field and has ultimately risen by promotion to the rank of Senior Medical Officer. He is in every way comparable with a consultant; and is indeed the person who is consulted by departmental M.Os. on specific problems; and it may be noted in passing that such public health medical officers as were at 4th July, 1948, graded as Senior Medical Officers in charge of tuberculosis (and who were transferred to Regional Hospital Boards on 5th July, 1948) have in most cases now been graded as consultants.

(c) *The Departmental Medical Officer*

11. The Departmental M.O. (sometimes termed the Assistant M.O.) is the grade containing more than three-quarters of all public health doctors.

12. While the Departmental M.O. may be in some instances concerned with Port Health work, with environmental hygiene, with local authority aspects of tuberculosis, and with the health of the elderly, most doctors in this grade are employed mainly at ante-natal, post-natal and child welfare clinics and in the school health service. In these services the principal duties are

- (1) the detection of deviations from physical, emotional or social normality at an early stage—long before the individual examined or his relatives have recognised the presence of any illness;
- and (2) advising groups and individuals on the measures desirable to remedy defects at an early stage, and to develop sound bodies and well-adjusted personalities.

13. This type of work calls for a high degree of skill over a wide range of physical and psychological medicine, and also demands a considerable knowledge of social factors as related to health. It may, incidentally, be noted that, whereas in the past a parent was at liberty to have his child examined by his general practitioner as an alternative to school medical examination, this choice was expressly removed by the Education (Scotland) Act, 1946—a recognition of the fact that special skills are necessary for the useful examination of an apparently healthy child.

14. In the first few years of his career the Departmental M.O. may legitimately be compared with the Registrar and Senior Registrar in hospital, although the junior public health doctor is in some respects better qualified and has in some respects a more responsible job:—

- e.g. (1) The Departmental M.O. normally takes his post-graduate qualification before taking up his first post while the registrar obtains his qualification during his period as registrar. [Until a few years ago the then standard scale specifying salaries and conditions—the Askwith Scale in England and the identical scale in Scotland—specified that the commencing M.O. should have the post-graduate diploma in public health and should have spent at least three years in the practice of his profession.]
- (2) The registrar in hospital has the aid of consultants and laboratories immediately available, whereas the departmental M.O. has often no immediately available source of help or guidance.
 - (3) It can reasonably be contended that more skill is required to detect early defects than to diagnose defects which are already so advanced as to make the possessor realise that he is ill. Further, special skill and special training are required for the ascertainment of mental defectives, and the classification of a "border-line" defective is a task of considerable responsibility.

15. The big difference between the Departmental M.O. and the Registrar is, however, that the former does not, in the majority of cases, ever rise to a higher grade. Over half of the doctors retiring from public health work at the end of their careers are ordinary departmental M.Os. Consequently, the Departmental M.O. of, say, between 5 and 30 years standing, must be regarded as the equivalent on the preventive side of the senior hospital M.O. in hospital, or perhaps of the general practitioner (except that in most cases the latter does not hold a post-graduate qualification).

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Salaries of Public Health Medical Officers

16. (a) The Departmental M.O. (corresponding initially with the Registrar and later with the Senior Hospital M.O.) is at present paid £1,050-£1,475.

The disparity between that salary maximum, for a doctor likely to end his career in that grade, and the present salary of a senior hospital medical officer is startling.

- (b) The Senior Medical Officer (corresponding with the Consultant) receives £1,520-£1,955—i.e. less than even a Senior Hospital M.O.
- (c) The Medical Officer of Health (who in small units corresponds with the consultant and in large units has analogies with the Consultant with a merit award) may be exemplified by quoting the maximum for three types of population unit. [Two maxima are given in each case, because Local Health Authorities have been given a range of discretion, although in most cases Local Health Authorities simply give the lowest amount within that range.]

Population						Maximum Salary
Under 75,000	...	...	...	...	...	£1,960 or £2,175
150,000-250,000	...	...	...	...	...	£2,555 or £2,870
400,000-600,000	...	...	...	...	...	£2,970 or £3,390

It may be noted that in Scotland (out of 271 public health M.Os. including 52 M.Os.H.) only two medical officers of health have population units of 400,000 or above.

17. At this juncture it may be useful to point out that the health services of Local Authorities are in grave danger of collapse through general failure of Local Authorities in recent years to offer salaries and promotion avenues comparable with those made available in the treatment services: the notorious shortage of recruits to health visiting (a profession in which the rank and file members have for about seven years been paid less than ward sisters, the hospital career grade, despite the additional obligatory qualifications of health visitors, and in which senior posts as superintendent or tutor are few in number and glaringly underpaid), the shortage of domiciliary midwives (nowadays paid less than ward sisters in maternity hospitals), the shortage of local authority dental officers and the shortage of sanitary inspectors all bear eloquent testimony to the unduly parsimonious attitude of local authorities by contrast with the relative generosity of the central authorities; and the qualitative shortage of public health medical officers, public health dental officers, health visitors, domiciliary midwives and sanitary inspectors is graver and more alarming than the mere quantitative shortages, although even the quantitative shortages (e.g. of health visitors and dental officers) are far greater than those to be found in most other professions.

A word on "Administration"

18. The low salaries of public health M.Os.—or at least of M.Os.H. and Deputy M.Os.H.—are sometimes attributed to the fact that, although they are recognised to be doctors who have specialised in a particular field, part of their work is "administrative". This is, of course, a curious argument which certainly does not apply outside the National Health Service: the Secretary and Deputy Secretary of a Ministry are not paid less than the professional experts employed in that Ministry (e.g. the Secretary of the Ministry of Health is not regarded as worth less than the Chief Medical Officer or Chief Architect, although the duties of the former are purely administrative); the University Professor is not paid less than his Senior Lecturer, although (while both undertake teaching and research duties without supervision) the essential difference is that the Professor has to devote part of his time to administering his department; the Manager of a firm is not normally paid less than the Chief Engineer; the Headmaster of a school is not deemed less valuable than the class teacher.

19. It seems to be only in the medical field that "administration" is stigmatised. It is perhaps worth while to consider the point in some detail. Administration is essentially the art of getting things done: the machinery of administration is provided by executive and clerical staff. The head of the organisation determines the

objectives. There are two classes of doctor whose administrative functions are comparable—the medical officer of health, and the medical superintendent of the mental hospital.

20. To take the medical superintendent first: he is undertaking clinical curative medicine on a specialist and consultant plane. He is also undertaking administrative duties within his hospital because his medical training and experience is essential for their proper discharge. That is to say, his administrative duties stem from his medical skill. If this were not the case an administrative officer without medical training, but with training in administration would be the appropriate person to appoint. The pattern of duties of the medical superintendent has evolved over many years of experience. He is responsible for the general supervision of the work of the medical staff, but the latter are not his assistants, and have a wide freedom in the discharge of their duties.

21. The medical officer of health informs himself of matters affecting the health of the community he serves, reports to the local authority, advises them concerning necessary action and puts into operation the schemes evolved. He holds his position because he has the whole technical knowledge gained by working in subordinate public health posts and in addition because he has the ability to organise his department so that the technical knowledge of his colleagues may be properly applied to the tasks in hand. In his case, too, his administrative duties stem from his medical skill.

22. Yet the medical superintendent of the mental hospital is paid as a consultant, whereas the medical officer of health is a consultant, paid at rates substantially below those applicable to consultants in the National Health Service although he is carrying out medico-administrative work of a highly skilled nature, and his colleagues ranked as senior medical officers and also carrying out consultant duties, are less well paid than even senior hospital medical officers: and his junior colleagues are condemned to perpetual registrarism.

23. It has also to be remembered that many senior clinicians devote a considerable part of their time to administration.

Effect of existing disparities

24. In the nine years which have elapsed since the commencement of the National Health Service many medical officers of health have seen their erstwhile junior colleagues translated to the ranks of hospital consultants. The tuberculosis officers, venereal disease officers and infectious disease specialists, who were formerly on the staff of a medical officer of health, have benefited; so also have the mental hospital superintendents, obstetricians, and other consultants. Not a few medical officers of health are in the position of having received £10,000 less in salary since the start of the National Health Service than these erstwhile junior colleagues. Naturally, this golden glitter around the hospital gates has diverted inwards many young doctors who would otherwise have looked to public health as a proper career. Who can blame them? Nevertheless, the dogma "prevention is better than cure" remains as true as ever, even though the National Health Service tends to make cure more profitable than prevention. The preventive services must secure their quota of good recruits. It is essential to promote health and prevent illness through well-developed maternity and child welfare services, school health activities, measures for the health-maintenance of the elderly, and so forth. It is essential to attract to the preventive field doctors able to undertake research into and prosecute campaigns for improved mental health—over half our hospital beds cater for mental ill-health—for social health, for reduced delinquency and absenteeism. These are the fields of today and tomorrow for the medical officer of health. The national interest requires that he shall receive adequate financial rewards, comparable with those of his hospital colleagues.

25. The curative services at best simply restore the *status quo*. The task of the public health services is to improve the health of individuals and of the community. It is therefore economically essential for the well-being of the community that professional posts (medical, dental, health visiting, nursing, etc.) in the public health services should carry remuneration, promotion prospects and conditions of service at least as good as are available in the curative services.

Examination of Witnesses

DR. H. D. CHALKE, *President*

DR. E. HUGHES

DR. J. B. TILLEY

DR. I. C. MONRO, *Scottish Branch representative*

SIR SELWYN SELWYN-CLARKE, *Medical Secretary*

on behalf of the Society of Medical Officers of Health and the Society of Medical Officers of Health (Scottish Branch), called and examined.

4438. *Chairman*: Dr. Chalke, you will be leading the discussion, as it were, with Dr. Monro representing Scotland? Has that got any special significance or are you really on this occasion pretty well as one?—*Dr. Monro*: I have a separate memorandum on which to speak Sir.

4439. *Chairman*: I must start, I think, by reminding you, Dr. Chalke, of the correspondence which took place just about a year ago between Sir Russell Brain and the Prime Minister, and our own public statement issued later. We know there was a strong feeling in the medical profession that their colleagues in the public health service should not be excluded from the scope of the Commission's remit and the Prime Minister was asked whether the terms of reference included them. The reply was that the remuneration of doctors employed by local authorities is excluded from the scope of the Royal Commission's recommendations, but any claim on their behalf through the usual machinery would necessarily be considered in the knowledge of any recommendations we may make. A public statement of the Commission followed, saying that the Commission are not asked to recommend remuneration for doctors and dentists employed by local authorities, but that these doctors and dentists are among the "other members of the medical and dental professions" on whose remuneration evidence will be received for the purpose of comparison. That is what we are doing today, and within that scope we hope you will feel free to talk as widely as you wish. We shall be asking you many questions, but it must be understood that recommending how much you should earn, is not within our terms of reference.—*Dr. Chalke*: We understand that, Sir, and we are very grateful for the opportunity of being able to say a few words.

We are purely an academic body. Our evidence here and the verbal evidence we shall give is based on that fact. We are speaking as an academic body and not as a body concerned specifically with medico-political matters.

4440. *Dr. Chalke*, I should remind you that this is a public hearing, therefore whatever you want to say will be heard by the public who, I see, include some of your colleagues from the Association of County Medical Officers who we are going to hear a little later.

Naturally we will want to question you thoroughly on your memorandum because, if we do not, nobody else will. We probably will not need to take a very long time because a good many points have been canvassed very thoroughly with a number of other bodies, so we will be concentrating primarily on those particular to you. I hope, however, that you will not take it for granted that those points we do not challenge or take up are accepted, or equally that they are considered irrelevant. It will be just that we do not need to question you about it.

We have allotted, as you may know, the task of looking at the various memoranda of evidence we have received, to sub-committees under our two legal members and in this particular case Sir David Hughes Parry will be doing most of the questioning. But of course you may get questions by anybody, and equally if you prefer one of your colleagues to answer any point, that is perfectly in order.—*Dr. Chalke*: Thank you, Sir.

4441. *Sir David Hughes Parry*: Dr. Chalke, I just want to get your paragraph 1 quite clear. You do regard yourselves as a scientific body, not concerned with remuneration as such?—Yes, that is in the terms of our constitution. We are precluded from anything else

4442. Yes, but I take it that you are anxious to have a contented set of members and that you want to recruit the best persons possible into the profession; that is your real interest?—That is the basis of our thesis, as it were.

4443. We recognise that, I think. I will have the opportunity later of asking the County Medical Officers in what way their Society is different from yours, but I think that question I had better reserve for them. You mention in paragraph 2 the type of person who is a member of the Society. Are they all doctors, qualified doctors?—There are a number of dentists, and one or two non-medical hygiene officers in the Services. Perhaps I should say that 99.9 per cent are doctors.

4444. Are they all full-time or some full-time and some part-time?—There are a few part-time but there again the vast majority are full-time career people in public health.

4445. You have partly answered the question I was going to ask next. You seem to cover a fairly wide field. What is the binding force that brings them together into one Society?—Hygiene! Preventive medicine. We have expanded very considerably recently in many new fields of preventive medicine.

4446. *Chairman*: But preventive medicine is found in other branches of your profession, apart from the purely local government one?—Yes, Sir.

4447. *Sir David Hughes Parry*: And the British Medical Association also has a public health branch or division?—The Committee, of which Dr. Tilley is the Chairman.

4448. Your first main point, I think, comes out in paragraph 8—"The position and prospects of a newly-qualified doctor". Naturally we are greatly interested in that. You say in your last sentence:

"Since his undergraduate training has laid its greatest stress on individual relationships in curative work, the young doctor who enters public health must have a special interest amounting to a definite sense of vocation."

I am not quite certain what you mean, whether you imply there is a neglect in the teaching of preventive medicine at the universities or what?—Sir, I think it is safe for me to say that not only recently but also in the last decade there

has been too much emphasis on disease in hospitals and not enough on prevention; and the young student who has the idea of spending his medical life in the work of prevention has to learn a great deal that he should have learned in his academic training.

4449. *Chairman*: You say "in the last decade". Do you mean that has become more pronounced than it was?—I think, Sir, the emphasis has been, since 1948, on curative medicine and treatment, much to the disadvantage of prevention.

4450. But was that the position before 1948 or do you say there has been a swing?—There has definitely been a swing.

4451. *Sir David Hughes Parry*: I am driving at the question of recruitment. If I may use this expression, the noses of the young people are not turned, when at the university, in the direction of public health; is that fair?—*Dr. Hughes*: I think that is a very fair comment, Sir. In fact I believe, if I may say so, that the undergraduate instruction in public health in certain medical schools has been certainly played down in our time. I think it is almost true to say that it has been almost omitted in the M.B. examination.

4452. That may be an element affecting the question of recruitment as well as remuneration. It is against your own interests, but that may be so?—*Dr. Chalke*: I do not think so. I think, in medicine there are fortunately still a large number of people left who think their rôle in medical life is the preventive side; those people still exist, despite the lack of remuneration and lack of status compared with other branches of the profession.

4453. I do not know whether there is anything further you would like to add to paragraph 8?—Whether you would include recruitment in that paragraph, Sir—*Dr. Tilley* might like to say something about the whole question of recruitment.

4454. I think we had better do that on paragraph 9. The first point you make in paragraph 9 in effect is that the medical officer of health is the only doctor required by statute to hold a higher degree or diploma. Let us hear a little about the diploma. Is it a hard test?—Very hard, Sir, and in addition it is

a diploma which cannot, in contradistinction to the Membership or the Fellowship of a Royal College be obtained when the young doctor is going on with his job.

4455. How many places are there where the diploma is granted—eight or ten?—In the region of eight or ten. Some of them in fact have had to close down within the last few years.

4456. And they have all got a limited number of students?—Yes.

4457. And a fair number of those students are in employment in the particular town where they are studying, is that right?—No, that is the point I am trying to make. To get the Diploma in Public Health, one or two local authorities now have schemes whereby they will allow people to enter the local authority service part-time and do a certain amount of work in the service, and take the part-time curriculum; but the majority of people have to do nothing else for a year whilst they are studying for the Diploma in Public Health; they are not earning anything.

4458. *Sir Hugh Watson*: Do they qualify for grants?—*Dr. Tilley*: No, Sir. I know of no occasion on which anyone taking a Diploma in Public Health course has qualified for any grant from a local authority or elsewhere.

4459. *Chairman*: At what age is this year when they normally take the D.P.H. course?—About the age of 28, I should imagine; 27 to 30 probably.

4460. *Sir David Hughes Parry*: At what stage do they take it? Is it after qualifying or do they take it after sampling general practice or after being registrars or what?—*Dr. Chalke*: It depends. It has changed a little recently but I imagine, after qualifying a doctor gets the urge to take up public health as a career and then he tries to find ways and means of getting his D.P.H. Some people do it after their national service; having seen the extraordinarily fine preventive service in the Army, they make up their minds to take up public health and then they have to find the money to cover the fact that they are not earning for a period while they are taking it. So, generally speaking, I should say it is two or three years after qualifying.

4461. *Mr. Bonham-Carter*: *Dr. Chalke*, is there any entry into the service at a considerably later stage in a

doctor's career?—Yes, Sir. There is another point mentioned later in our memorandum in another context, the paucity of entrants and people who apply for jobs at the present time. Some people have come in much later. I think it is fair to say there were other forms of entry into public health in the old days. For example the chest physician, the tuberculosis officer who in the past, as you know, was an employee of the local health authority and very often a deputy medical officer, came in that way.

4462. *Sir David Hughes Parry*: But at all times he is faced with the situation where he has to keep himself probably for a full twelve months?—Yes, Sir.—*Dr. Tilley*: Certainly for an academic year.

4463. It would be interesting to us to know if you have any views as to the sort of time at which it would be ideal for them to enter. Should they have been in general practice to see that before they enter, or would it be better for them to take an appointment, if they can get it, as a registrar? Have you any views on the desirable time at which they might enter, as a general body.—*Dr. Chalke*: Sir, I would say, again in the past, the person who became a medical officer of health eventually had done a host of jobs, had spent time in a fever hospital, or a venereal disease department; he had been a tuberculosis officer and then very often he had been a house physician in a children's hospital. There are so many facets of public health work. The wider the experience of the individual parts of the service the better. Most of us have done a little time in general practice, six months or a year, or some locums. All of us have done jobs in hospitals, in some cases quite senior jobs, and it is after that we have come to this wider field. Preventive medicine is the only branch of medicine at the present time which has innumerable facets. There are no branches of medicine in which preventive medicine does not take an interest.

4464. I see also, *Dr. Monro*, that you raise this matter in your paragraph 14. I do not know if there is anything you would like to emphasise on that.—*Dr. Monro*: That is the point of the statutory obligation?

4465. The statutory obligation and the time at which the persons enter into the field of public health.—I for my part took my Diploma in Public Health just on nine years after qualifying in medicine. I did it late because I had sought a career in one of the colonial medical services and after three and a half years, in all five years overseas, I found myself physically unfit; so you may say I decided upon public health approximately four years, or rather entered public health approximately four years after qualification. Last year I took on two new doctors to the staff. One had just four years from his date of qualification and the other rather longer, about six or seven.

4466. That would be typical or normal?—I think so, except where you are dealing with women, because a woman does not have her national service and there is, I think, a certain attraction to women to go into the maternity and welfare services; they may see that as a career and vocation rather earlier than a man going in for public health would see the whole field of public health as his vocation.

4467. It may be that when the Vice-Chancellors of the Universities are before us we might take the opportunity to ascertain the number of those who are being trained in public health at the different universities and those of them who are full-time in training and part-time. I have an impression there may be quite a fair number in part-time employment during their training but it may be we will get those figures from the Vice-Chancellors.—*Dr. Chalke*: There is one danger there, Sir; although no doubt the numbers of people taking the diploma are up or at least have not fallen very much, a very large proportion of them in London and other Universities are people in the Services. Nowadays in the Forces everybody is encouraged to take a Diploma in Public Health: so the numbers, though large, are very largely due to people who do not enter civilian public health.

4468. *Chairman*: When they are in the Services taking this, is that also without remuneration or can they take it while they are serving officers?—Yes, Sir. In the Services the D.P.H. has perhaps a higher status than in civilian life.

As you know, senior officers are asked if they would like to take a higher qualification, and a lot decide to take the diploma of public health. In the Army it is called Army Health and it automatically carries specialist rank; so the Services at least recognise their status as specialists.

4469. He is seconded and is still being paid by the Forces and is able to go on earning while he gets his D.P.H.?—Yes. I am not qualified to speak for the Services but I am quite sure that is what happens.

4470. *Mr. Bonham-Carter*: Do you know if the men going into the Services are National Servicemen? Is this a situation which is going to change materially if and when National Service comes to an end?—No, Sir, they are not National Servicemen but career people in the Services who want to become specialists; they decide on public health and stay in the Services. They know they can get equal rank, status and pay with a consultant or surgeon, physician and so on. There is equality in the Services.

4471. *Chairman*: Is the D.P.H. a useful diploma for people to have who are not in the public health services?—Yes, Sir. I would like every general practitioner and every consultant to have it.

4472. Do many general practitioners or consultants have it?—No, Sir.

4473. *Mr. Bonham-Carter*: Or industrial doctors?—Some do.

4474. *Chairman*: Do you know how many people on the medical register, for instance, have the D.P.H.?—I would not hazard a guess, Sir. You mean, altogether?

4475. Yes.—Two or three thousand, would it be? I have no idea.

4476. You have 2,300 members yourself?—Yes, Sir.—*Dr. Hughes*: First of all, Sir, on this question of length of period before you enter the public health service: at my time I had done seven years in various hospital jobs and I think that is fairly typical. Now of course the National Service commitments do alter things quite a bit. But it is a fairly long period before a young doctor decides on a career. On the question of industrial medicine in the D.P.H., it depends on which school you qualify in. At the School of Hygiene, for instance,

it is possible to take overlapping courses, industrial health and public health, and a great many people do back the thing both ways.

4477. *Sir David Hughes Parry*: If I may summarise, as I see it now in the light of your replies, as compared with a person going into general practice, the person who goes into public health has three, four, five, six or seven years of some general work either in the public health field, or specialising in tuberculosis or something of that kind, and therefore his training is longer than the training required for the person to enter into general practice. As regards consultants on the other hand, we have evidence to the effect that it takes at least seven years to qualify to be considered for a consultant. Would it be right to say that your period of training is not quite so long and perhaps not quite so competitive as that particular period of training?—*Dr. Chalke*: With the proviso that in our period we are earning nothing when we are taking the D.P.H. and very little when we are doing the house jobs before it. But we must not forget a very large proportion of the people have higher qualifications in addition to their D.P.H. There are a number of people, members or fellows of the Royal Colleges, and certainly doctors of medicine in public health as a whole. In fact to get the senior posts in public health one requires to be well qualified.—*Dr. Monro*: One additional point, Sir: their training in public health does not end with securing the D.P.H. and securing their first appointment. It continues thereafter.

4478. The training of none of us ends with an appointment.—No, but the training does not end with entering the service.

4479. *Mr. Bonham-Carter*: I wonder if you would explain that, Dr. Monro, following Sir David's remark. Do you have to go on with a particular line or course of study?—Not in that sense, but the new entrant is set to work of a kind he has never done before and he has to gain experience and judgment. For instance, it is only after he gets his first appointment that he perhaps comes up against the difficulties of deciding if a child is mentally defective.

4480. *Chairman*: But that surely is as Sir David said, something that must happen in every profession?—As I understand it, Sir, that phase is gone through

by the senior registrar. In other words our public health new entrant and the hospital senior registrar entrant are comparable. Both are doing useful work but both are still learning their jobs.

4481. *Sir David Hughes Parry*: I think I have that point. May we move on to paragraph 10? You use the word "departments" there. I am not quite certain—is this a department of central government or local government? I thought it was a department of local government.—*Dr. Tilley*: This is a term, Sir, first used by the Committee which sat under Lord Askwith. This is a term used for the basic doctor in the public health service, the school medical officer or the doctor working in the child welfare service, that is, a doctor working in the school health department or the child welfare department of a larger health department. That is the reason for the term, if you like, "departmental officer"—not a doctor in charge of a department, but a doctor working in a department.

4482. Who pays him? Is it the central or the local government?—Directly, Sir, the local government authority.

4483. *Chairman*: Is he, for administrative and disciplinary purposes, responsible for instance to the director of education or to the medical officer of health?—To the medical officer of health, Sir.

4484. In your case as an example, Dr. Tilley, taking a good sized county, how many doctors would you have responsible to you?—In this grade, Sir, about fourteen; fourteen whole-time doctors in this particular grade responsible to me.

4485. I suppose in a borough like Reading, being more concentrated, you would not have so many?—*Dr. Hughes*: I have five, Sir, plus a deputy.

4486. Five in this grade?—Yes, Sir.

4487. *Sir David Hughes Parry*: What proportion of these are in your 2,000 members? Does this particular grading cover the majority of your members?—*Dr. Chalke*: I think so.

4488. You have a fair number of persons who are not paid directly by the local authority. I am just wondering how many are covered by these figures.—You are referring to paragraph 3 as well, are you, Sir David, in which we give roughly the proportions?

4489. *Chairman*: Yes, you say 2,300 members but 40 per cent of them are employed by local authorities under medical

officers of health, 25 per cent are medical officers of health and 10 per cent are retired. That is the paragraph you are meaning?—Yes.

4490. What proportion of the 40 per cent would really be in this grade—medical officers employed in departments with a salary range rising to a maximum of £1,475?—*Dr. Tilley*: Certainly more than 50 per cent.

4491. And most of them under, say, age 40 to 45 or up to all ages?—*Dr. Chalke*: Most of them under that age. It is difficult to say but the large majority are in that category.

4492. *Sir David Hughes Parry*: There is another question on the figures there. You give the figures under the 1950 award and then the 1956 award, and then you say "over 600,000—at discretion". I wonder how many there may be of those. I want to see the structure.—*Dr. Monro*: There is only one in Scotland.—*Dr. Tilley*: Speaking without checking this, Sir, I think about 12 to 14 in England and Wales.

4493. Between the 400,000 and the 600,000? This is only for the purpose of seeing the structure.—*Dr. Monro*: Again, only one in Scotland.—*Dr. Tilley*: More than 12, Sir. It is a pyramid, if you like, with the London County Council at the top of course—the one single office—the London County Council with a population of over 3 million. Then there are three authorities, I think, with 2 million population and then about four with 1 million, including Glasgow and Birmingham, and it spreads out; but the vast majority are well down below the 400,000 of course.—*Dr. Chalke*: A graph, Sir, or public health salaries is flat rising practically not at all, until the sharp peak at the end; so different from other grades in which they do go up gradually, and there is not that final sudden peak to the end.

4494. Paragraph 13, which is a matter causing a certain amount of disquiet, naturally, the one where you declare that there is a difficulty experienced at the present time in recruiting anything like enough in quality as well as in quantity. Shall we deal with the quantity first? Do you know of any recent appointments, in your experience? I would like to know how many applicants you had, that sort of thing; that would give us some clue.—*Dr. Hughes*: I think it is a thing that

has worried us all. Up to about two years ago when I used to advertise for an assistant, one got hardly anyone at all worth considering. We did in fact introduce a special training scheme but we are rather unusual in that. That has improved, but the quantity was very small indeed, and certainly did not include many people who wanted to take public health as a career. And it was because of that that my Council agreed to have what we call an assisted training scheme. We are unusual in that but it was because we were so dissatisfied with the quality of the applicants and the quantity of applicants and also the length of time they stayed.

4495. Have things improved in the last two years?—Perhaps I should not take this example as typical because we have introduced a scheme to help people. We have said they have to have the D.P.H. or get it as soon as possible and we are prepared to second them on three-quarters the minimum salary. We have had better applicants since then and in return we ask them to stay for three years afterwards. I am hoping that is going to show an improvement in the situation but that type of scheme is very unusual. I think my colleagues will share the experience I had two or three years ago.

4496. Have you had more recent experience? Is it better now?—We have just made the second appointment under this assisted training scheme and I am hoping that will see us through for the next two or three years at any rate.

4497. And the applicants were better?—They were men anxious to take up public health as a career, which was one of the things we were after.—*Dr. Chalke*: My experience—I remember the difference now from 15 or 20 years ago or even more, when one applied for appointments oneself. There was always an enormous number of applicants then. My experience in the last year or two has been there are very few men, a large number of women, but very few men applying for appointments who were quite obviously the type of person who before the war came into the public health on a career basis. There are very few of those people and there is a strong tendency for people not to stay in as long as they did before. In my youth, if you went into public health that was your career and you stayed there.

Now there is a tendency to go out if you can. It has been very hard in the post-war years to get a suitable male who we are quite sure will stay and whose aim is to be a medical officer of health.

4498. So you are satisfied there is not the number? That is what I am concentrating on. There is not now, and there was before the National Health Service?—Yes, Sir.—*Dr. Tilley*: I think that is quite clear and every authority in the country would confirm that the number of applicants is very considerably less than it was before 1948. The thing that concerns us very much at the moment is that, of those who do apply, we do not see in them the quality that we would hope to see for the leaders of preventive medicine in this country in the future.

4499. It may be that that can be improved with these assisted schemes of training?—That may be so, Sir. But, Sir David, you did ask earlier if the training of a man going through the public health service was less competitive than the consultant. I think that perhaps at the present time if by competitive you mean competition to obtain posts and advancement, one would have to accept that that was so. But it was not so prior to 1948 and what has changed of course is the relativity of the remuneration that one may earn in the public health service as compared with the other parts of the State medical service. It is on that basis that I doubt very much whether even with assisted schemes of training for the Diploma in Public Health, we can expect as many of the most able men and women to come into public health as we could if the prospects in the two services were comparable.

4500. *Mr. Bonham - Carter*: Dr. Hughes, you made the point that one of your difficulties has been that men have left the service. You have not been able to keep them and Dr. Chalke, I think, confirmed that. Do you mean they leave your own particular authority or that they went out of the public health service altogether?—*Dr. Hughes*: The Press is here and I hope they will be discreet. I work for a pleasant town and a good authority. I hope they will not think I am criticising my authority; but in the last two odd years I have had four people leave, the first after six months

to industrial medicine, the second stayed about twelve months and then went to a senior post in a large city. The third stayed six months and went to America to become a medical officer of health himself in Carolina or somewhere like that, and the fourth is leaving to go to America next month. I will stress again that I have a very good authority and it is a very pleasant town I live in.

4501. I can confirm that.—If I might ask for that to be treated with discretion.

4502. *Chairman*: All four remained in public health?—One has gone into industrial medicine, two have gone to America and one has remained in this country.—*Dr. Chalke*: A large number went into industrial medicine and other branches after the war, I am sure partly for financial reasons.

4503. *Sir David Hughes Parry*: Dr. Monro, I think you pay a good deal of attention to that in your paragraph 17:

"At this juncture it may be useful to point out that the health services of Local Authorities are in grave danger of collapse through general failure of Local Authorities in recent years to offer salaries and promotion avenues comparable with those made available in the treatment services."

That is a matter which concerns us.—*Dr. Monro*: I think that is quite true, that we are just not getting the right kind of people and we are not getting the right numbers. Two years ago I had two vacancies and they were duly advertised. There were four applicants. One was already working in an industrial concern, a nationalised industry, and he found he could not afford to come back to a local authority public health service although he would have liked to do so. One was an Indian lady who had just completed her D.P.H. She wanted a restricted period of experience in this country, and I regretted being unable to help her out—I would have liked to but things being as they were I did not feel justified in doing so. The other two: one was a woman in her middle thirties with good general practice experience and she has done all right so far in public health, and the other was a married woman in her forties seeking to augment the family income. Neither of these two had the D.P.H. They both settled down adequately, doing the kind of work within their capacity, but they will never advance in public health.

4504. Thank you very much. I think you have made your point, to which we must pay attention. Can we move forward to paragraph 14? Something has gone out of place here. It is headed "Comparative treatment for Income-Tax purposes, etc."

"The Society does not propose to offer any comments on this topic at this juncture. Nevertheless, it is particularly interested in securing an increase in the number of appointments of public health medical officers as consultants in preventive medicine to hospitals . . ."

I am not quite certain how the two points come together.—*Dr. Chalke*: No, Sir. We really meant the whole question of salary to be brought in at that juncture, I suppose. It does seem a little out of context. Could we dismiss the whole question of income-tax Sir, and go on to the second part?

4505. We have heard a good deal about this income-tax question and we are not going to press you on it.—We are interested naturally in the question of consultants mentioned again in our paragraph 22. As you know, Sir, this is a Guillebaud recommendation and a point I might touch on perhaps is this widening sphere of preventive social medicine today in which the hospitals are much more interested than ever. The whole question of hospital treatment now is bound up with the domiciliary side and local authority services have been brought more and more into the picture. And it seems inevitable the local authority consultant must be in hospitals and he must have the necessary status for that work. That in brief, Sir, is what we mean.

4506. I think I have got your point. Paragraph 15—there you indicate that you are not eligible for a merit award; that is because you have not been doing clinical work?—No, Sir. We make no comment on the desirability for merit awards or the method of giving them. The point we wish to make is that there should be some comparable means of financial reward for distinguished members in our branch of the profession, the same as in others, and our view is that we can reach the same end by increasing the salary level proportionately.—*Sir Selwyn Selwyn-Clarke*: May I clear one point, Mr. Chairman, arising out of Sir

David's question? It is a fact that a very large number of public health medical officers do clinical work and there are some public health medical officers who are consultants in clinical work. I should not like Sir David to go forward with the idea that public health medical officers do not do clinical work and are therefore not eligible for such additional higher salaries or awards given to our colleagues in other branches of the profession.

4507. Does that refer to part-time? It may refer to part-time, clearly.—As an instance, the medical officer at Oxford is a consultant in infectious diseases and has beds in the hospital at Oxford, dealing with infectious disease patients.

4508. He is a full-time officer?—Yes, with the City of Oxford Corporation.

4509. *Chairman*: He is also a consultant?—Yes, Sir.

4510. Is he eligible as such for merit award?—No, Sir.—*Dr. Chalke*: A large number of medical officers of health act in this way now as consultants to the groups and hospitals. They have clinical responsibility. I have clinical responsibility in certain respects. I can not imagine anything more important clinically than the diagnosis of smallpox or anything more important than to be called in to discuss an outbreak of infection, food poisoning and so on. It depends on what we mean by the word clinical. To me the preventing of outbreaks is at least as important as the work of people who say they have clinical responsibilities.

4511. I would like to follow Sir Selwyn's point. Such a medical officer who has beds at his disposal in a hospital has the ultimate responsibility for the individual patients?—Undoubtedly, Sir. He controls and advises on their treatment.

4512. I have not quite understood how it is that he was not, as such, eligible for consideration for a merit award.—That is one of our contentions, Sir.

4513. *Mr. Bonham-Carter*: He is specifically excluded because he is the medical officer of health?—*Dr. Chalke*: Paid by the local authority.—*Dr. Monro*: There is an arrangement by

which a medical officer of health may be also employed by Hospital Boards.

4514. *Chairman*: Is he in contract, for instance, with a hospital authority?—I think the arrangement is between his employing authority and the hospital as a rule, but according to which service he gives the most of his time his status and pay is determined. I can quote some medical officers in the far north of Scotland who hold appointments as medical officers of health for very small authorities for less than half their time and the remainder is devoted to the Hospital Board. They are paid, not as medical officers of health, under Whitley Council Committee C, but as, in this case, senior hospital medical officers.

4515. But if they are paid as consultants for part of their time, presumably they are eligible?—I presume so.

4516. In England, are they not employed by the hospitals on a sessional basis?—*Dr. Tilley*: I think, Sir Harry, there are two distinct arrangements here. One is, as Dr. Monro has said, where an arrangement is entered into that a medical officer of health will work for the hospital authority for less than half of his time. He may continue to receive simply the salary of a medical officer of health and a fraction of his salary is reimbursed to the employing authority. There is a separate system. I have no knowledge how widely the two systems are used; but there is, I know, one instance where the medical officer of health is in direct contract with the Hospital Board for two-elevenths of his time and presumably for that portion is eligible for merit award. That does exist, Sir, but I think it is far from common.

4517. You talked about the pyramid earlier, the one with the London County Council on top. In a sense that gives the competitive opportunity for the good medical officer of health to advance, if you like, from the local authority with a population not exceeding 75,000, up in stages on merit and in competition, to a much bigger position with bigger salary. Is that not so?—*That*, Sir Harry, is true. One of our difficulties is that the opportunities at the top are very limited. That is something, as far as I can see, we cannot at this moment make any suggestions about. Secondly, the remuneration for those opportunities is very much less than the top opportunities in other branches of the National Health

Service. In other words, Sir, were the top of the pyramid to receive remuneration equal to a consultant with a full or top merit award, there would be something comparable which would be an incentive, which would be perhaps going a good way towards making the public health service sufficiently attractive to attract good people.

4518. Has that position altered to the disadvantage of your branch of the profession since before the war or before the National Health Service?—*Sir Harry*, I can only say I believe that is so. I am unfortunately not able to quote the very top figure, simply because I do not know it, but it is my belief that the medical officer of health for the London County Council, for example, received remuneration which was certainly comparable, and in my own opinion was greater than whole-time consultant people in any hospital services in the country at that time. It is very difficult to get an exact comparison because there was no whole-time paid service with any agreed scale with which this could be compared. I am speaking from memory—the whole-time specialist jobs, I know, in hospital at that time certainly carried a salary less than the medical officer of health of the London County Council. Now that position has been reversed, Sir. I do not know what the arrangement is for merit awards for whole-time consultants—it is not my field—but I imagine the whole-time consultant is entitled to a merit award in some circumstances.

4519. *Sir Hugh Watson*: Before the war there were very few medical whole-time consultants. The majority of consultants before the war were people who were paid little or nothing at all by the hospital, to whom they gave voluntary service; they earned such fees as they could—and some of them very large fees—outside.—*Yes*, that is true, but there was before the war something with which the medical officer of health could be compared. After 1929 when local authorities were improving their services, authorities like Middlesex, the only one I can quickly remember, did employ whole-time specialists of very high calibre but the medical officer of health received a higher salary.

4520. *Chairman*: *Dr. Tilley*, you are very anxious for reasons we can understand, to make the comparison between

the medical officers of health and the consultants. Perhaps we can talk in terms of the general practitioners because there we do know from the Spens Report about the sort of level of the remuneration then and since; and you are competing with other branches of the profession, including the general practitioners for recruits. It would seem from the figures in the County Medical Officers' memorandum that the increases in the remuneration of medical officers are at least of the same order, are they not, as the increases received, as far as we know, by general practitioners under Spens. I do not know whether you know the County Medical Officers' memorandum. I am not looking for the exact comparison but just want to know whether you really can feel, with the different branches of the profession, that things have gone very much to your disadvantage since the war.—*Dr. Tilley*: I am at a disadvantage, Sir Harry, in that I have not the memorandum here. I think that question could well be asked of my colleagues.

4521. I think you have an idea—you are not able to substantiate the figures—that in fact other branches of the profession have gone ahead more quickly than the medical officers.—Yes, Sir. There is a factor that must be borne in mind here. When people came into employment in local government and public health services before 1928 they were entering a pensionable service. There are many factors involved in a man making his decision as to what particular branch or line he is going to take in his career and I think we must accept that the prospect of a pension will attract a large number of very able men who, without the opportunity of a pension in other spheres, would not go there. Today that position no longer holds. The young man qualifying knows that whichever branch of the National Health Service he goes into the question of pension remains the same and therefore that attraction to the public health service has gone. As we feel that the remuneration is also less attractive than the levels of today in the other services, we seriously feel that the future, not so much the present occupants of posts, but the future is very bleak as far as maintaining a good standard in looking after the community health of this country is concerned.

4522. *Sir David Hughes Parry*: May we move on to another matter, paragraph 17 of your memorandum:

"The salaries of public health medical and dental officers should not be related in any way to those of non-medical officers employed by local authorities."

The word "related" there rather confused me. There must be surely some relation between the salary of the medical officer of health, in a particular place, and the other higher officers?—*Dr. Chalke*: There may be some relation, Sir, but the basis of our argument is that we should first and foremost be paid as doctors. We are first and foremost doctors and our salaries should be relevant to the salaries of other doctors or specialists in all branches of the profession. It is only a secondary point that we happen to be employed by local authorities, but because our branch of medicine is in the field of local authority work we always find ourselves related—as we say in paragraph 20 about the Industrial Court—our salaries are always so closely linked with those of other chief officers that the fact seems to be forgotten that we are primarily doctors and want to be treated as doctors in status and pay.

4523. Paragraph 21—the opening sentence says:

"Members of the public health service are at a special disadvantage with regard to superannuation benefits. Non-medical local government officers commonly join at a much younger age than is possible for medical officers. . . ."

and so on. You want to establish a relation there, do you not?—Only because it is our last hope, Sir, as it were, in view of the fact that this relationship persists in everything, so surely we can stake our claim for some part of the benefits which other local authority people get. I think that is fair, Sir.

4524. *Chairman*: There must in fact, Dr. Chalke, be a relativity here between you and other doctors since you all come under the same original recruiting and go through the same medical schools at the beginning; but there also must be in fact a relativity among the employees of any large employing body, whether a local authority or a big industrial body.

You cannot ignore your colleagues in other walks of life, entirely.—No, Sir. We do not quite mean that there should be no relationship at all.

4525. You do say it should not be related in any way.—We mean, Sir, we should not as doctors be prejudiced because non-medical members of local authority staffs get certain salaries. There is always this close linkage, but there obviously must be some connection.

4526. You say status and pay; in what way are you prejudiced in status?—I do not know that we are prejudiced in status. But the medical officer has not the status, for example, or the pay of the Town Clerk. For example in the Industrial Court it was said—I think someone said—"No, we could not possibly have a salary scale of this sort because the medical officer would be getting as much as the Town Clerk." There is always such a close link between the two. We want to be treated as doctors, Sir.

4527. Do you think medical officers of health might have been aware of the position of town clerks when they entered the service?—I am sure they would but they were so interested in preventive medicine and did not look so far ahead, to consider such matters.

4528. Dr. Tilley said they looked so far ahead as to think of a pension.—Dr. *Monro*: Sir, I think there is a point worth bearing in mind, that in 1938 the total personal income, untaxed, in this country was £5,078 million, of which £212 million went to the rates. In 1956 the figure was £17,035 million income, of which £551 million went to rates. If the rates had risen proportionately they would have been £711 million. I think quite frankly that the local authorities, our employers, are slipping and it is not only we who are suffering but the sanitary inspectors, the water engineers, the road surveyors and all the rest. If you go into it you will find similar difficulties of filling vacancies, and incompetent staff. I would like to say this and this to me is frightfully serious: without the sanitary inspector, the water engineer, the drainage engineer and the man who empties the dustbin, 50 million people cannot live in this island.

4529. Mr. *Bonham-Carter*: Dr. *Monro*, I take your point. What is worrying me a little is that one might find, if we went into a different branch of medicine—the industrial branch—if they argued the

same way as you are arguing it might be very strongly to their disadvantage. Would you think the principle you are putting forward on this is really (a) a practical one, and (b) has some advantage to the profession as a whole? In other words would it not be better to establish a doctor in the community in which he is working, and pay him in accordance with his skill?—Dr. *Monro*: I am not sure I quite grasp that.

4530. You are on this point that you are at a disadvantage by your remuneration being in relation to that of other local government officers. There are other doctors who may have the same situation, that is to say their remuneration is related to people whom you may think it would be to your advantage to be related to. Therefore you might have another branch of the profession arguing entirely against this point of principle. Is not really the answer that it is an exceedingly difficult one to uphold in practice?—Dr. *Tilley*: I am not so sure, Mr. *Bonham-Carter*. I take your point, and I imagine the group of doctors we may be thinking of must stand in relationship to people with whom they work in an industrial field and their colleagues within the hierarchy of the company, and this may be to their advantage. That does not hold in the public health service. This is not quite a fair thing but it comes to me that this might be regarded as several separate companies working in the same building. The medical officer of health is running his health department. He may have very little contact indeed with the gentleman who is running another department of the local authority. He may not even see him for months on end. He may not be concerned in what happens in a particular department. It seems to me unreal to relate A to B if you are going to recruit into A from a particular field, which is the medical profession. We all feel this very strongly, that our relationship in a public health department is with the doctors who work and live in the community which we serve, the consultants, general practitioners, and the hospitals. Our relationship, Sir, with the other officers, county surveyors and so on, by and large is simply that of a member of the public and we certainly do not feel that parity which may be suggested to you from other sources is at all a proper method of procedure.

4531. It has not been suggested, but experience suggests that it is the employer

which causes the common binding factor. In groups of people employed by the same person almost inevitably you get a relationship built up through the employer.—*Dr. Chalke*: With the change of structure in 1948 the paradox arose that many persons who were previously deputy medical officers of health now worked under another authority and became consultants. The chest physicians, tuberculosis officers and so on, they were all deputy medical officers of health, and they immediately became consultants because they were employed by another authority. The venereal disease consultant and so on, all benefited by working for another authority. But, more important, although we medical officers of health are actually employed by the local authority, our work has broadened so much, we spend so much time working in the hospitals, in and out of the hospitals with general practitioners. We are in fact primarily doctors, and we should be considered as doctors as part of the medical services of this country.

4532. *Sir David Hughes Parry*: I see the argument all right, but I should have thought the salary of the medical officer of health must have some relation to the salary of the other members of other professions working for the same local authority?—Exactly, in the same way that the salary of a senior medical officer in the Army is in some way related to that of other officers, but he gets a lot more.—*Dr. Hughes*: There is one point, if I may come in. The salaries we are discussing in the main are, if we may use the word, imposed salaries, whereas in industry I imagine that the contracting parties settle it between themselves. There is a national award for National Health Service salaries. I do not think the comparison is quite true.

Mr. Bonham Carter: I wonder if you would argue the other way if it was to your advantage.

4533. *Chairman*: *Dr. Chalke*, the important thing really is whether you are getting into your branch a fair proportion in quality and in quantity of the whole of the entrants to the medical profession?—*Dr. Chalke*: Yes.

4534. That is really the point. We have had a good many statements here which perhaps necessarily are rather difficult to substantiate by statistics. Do you

think you can do any more than that, or would you prefer it to remain as a generalised thing?—I think we would have to generalise.

4535. You know, *Dr. Chalke*, of course, that we ourselves have been making a survey of the actual earnings of doctors employed in the National Health Service and of members of many other professions. In your particular branch we know the figures of the scale?—Yes.

4536. But that will show some interesting figures about what is actually happening in the different branches of the profession.—All medical officers of health are not in the National Health Service.

4537. All medical officers are not?—Not all. Some of them are not—in the metropolitan boroughs, for example.—*Dr. Hughes*: One point on that is if you are going into figures you may consider the question of vacancies and so forth. Establishment is a very different subject. I think it is true to say most of us realise we require more staff than we have got, and it might be we could get authority to increase the establishment, but because of this difficulty we have not pressed for the increase. I think some of us are in that position.

4538. You feel you are under-staffed?—We are under-staffed, and there is really little point in asking for more staff when we have an awful job in filling satisfactorily the establishment we have got. In my own case, for instance, I think probably, especially with this new work which is coming along on polio vaccination we shall want more staff, but there is little point in asking for an increase in staff when it is difficult to fill the establishment we have got.—*Dr. Chalke*: It is inevitable in my view that this side of preventive medicine will expand and we will require more staff. It is inevitable; more and more people are being treated at home. The domiciliary services will increase, home treatment will increase, and the services we must provide, home helps, health visitors, and so on, must increase, and our link with the hospital will increase. We shall want to expand, and it is doubtful whether we shall get the staff to do it.—*Sir Selwyn Selwyn-Clarke*: Might I add one further point in connection with the seventeenth paragraph of our memorandum? I would like to refer you, Sir, to the memorandum

from the Local Government Board in 1910, if I may quote from it:

"The salary offered to a medical officer of health who devotes his whole time to public health work should in the Board's view be sufficient to attract men with good qualifications and to retain their services. The medical officer should not be placed in a position of inferiority in this respect to other medical men in the district. It is not sufficient a medical man is found to accept a salary offered. It is important the salary should be such that it will be worth the while of a capable man to accept it".

We have heard a great deal of criticism against the National Health Service on the grounds that it is made up of three divisions, and those three divisions are lacking in the co-ordination that should exist between them. Some few years ago the late assistant medical officer, the senior administrative officer in Newcastle wrote that one of the chief failures in co-operation between hospital and local authority services lies in the division of the medical profession into two salaried groups of grossly unequal status. Although our Society has nothing to do with the terms and conditions of service—it is outside our purview—we are very concerned with the quality of the recruit to the service. We are very anxious, just as they are in Scotland, not to see this service disrupted with all the consequences to the welfare of the community. I do think that we are entitled to push our claim that we should be regarded as doctors, and have our conditions determined on that basis, and not on what a borough engineer or borough surveyor, or this, that and the other, a layman, receives. Although of course there must be some relativity that should not come into the picture in so far as the determination of the actual remuneration is concerned, in my humble submission.

4539. Most of your members are in fact employed by local authorities?—That is so.

4540. I suppose they put this point to their own employers, to the local authorities?—I would not know whether they have or not.

4541. I suppose, Dr. Chalke, it is quite likely that this point has not escaped your attention on those occasions also, is that right?—Dr. Chalke: No.

4542. Are the local authorities satisfied with the quality and quantity of recruits they are getting, or could you not give a generalised picture on this?—I could not say whether they are or not.

4543. But it is very much in their interests to have their services properly run?—We know. Whether our lords and masters know I just do not know.

4544. They are the people whom you would normally tell if you thought you were unable to get, for instance, any applicants for vacancies?—They know that. They do know that because they are the people who make the appointments on our recommendations.

4545. *Sir Hugh Watson*: I suppose Dr. Monro has made it plain to the County Council of Lanarkshire about the situation which exists in getting assistants in his services?—*Dr. Monro*: They knew the difficulties that I had in the first instance, though I must say quite clearly in this that through canvassing the D.P.H. classes just before the "haich", I secured my requirements without undue difficulty.

4546. *Chairman*: You mean yours is rather one of the more enterprising authorities that gets the degree men?—I would only admit to being lucky.

4547. *Mr. Gunlake*: I wonder if I could ask a question which has been rather worrying me in the last hour. You have said a good deal about your special interest in preventive medicine as a branch of the science, and you have also talked about the difficulty of recruitment into your particular branch of the profession. It might, I think, be superficially inferred from that line of argument that it is the special duty of the local authorities to foster and encourage preventive medicine, but that is not the position at all. Preventive medicine is a thing which is worthy of encouragement of itself, and it should not be the local authorities' specific responsibility to do so. If it is not being encouraged as much as you would like, it might well be the fault of central government in general rather than of the local authorities.—*Dr. Chalke*: We do look upon preventive medicine as in the purview of medical officers of health.

4548. That is the point I wanted to bring out, because preventive medicine on the one hand, and social or community medicine on the other, are not the

same thing, they are not identical.—They are so bound up one with the other. There is no term which includes the modern concept of promotion of health and positive health, and so on, and all these terms in my view mean more or less the same thing. The point surely is this, that the need for health promotion, call it what you will, social medicine, has widened so much that everybody must take a part; but the medical officer of health seems to be the pivot, the central person, the co-ordinator. In the modern tripartite National Health Service the one person who co-ordinates the work from hospital to general practice, industrial medicine, the one essential person is the medical officer of health, and you must have him. He must co-ordinate all this, he must stimulate health education in the public, and stimulate his colleagues to join together to improve this health promotion which is becoming more important every day—and it is becoming even more important than it has ever been in this automatic and atomic age which is now beginning. The person who must control and co-ordinate all this is the medical officer and the control centre is the public health department.

4549. *Sir Hugh Watson*: Are medical officers of health frequently consulted by general practitioners?—Frequently. That is a very gratifying feature in the last few years. The general practitioners are now coming to regard the public health service as something which is inevitable for the satisfactory carrying out of their practice. Take, for example, the case of health visitors. In certain cases health visitors are seconded to groups of general practitioners to work with them. In other cases there is a shortage of health visitors and they cannot be used more widely, but the general practitioner is coming to look upon the health visitor as his handmaiden, as his almoner who does the social work for him, particularly with the new problem of the aged. He also looks upon the home help service as an essential part of his service; and to co-ordinate all this work and be the link with the hospital, on the geriatric side, the old people, there is the medical officer of health—more so than ever, because public health has changed from the old days of infectious disease prevention, sewers and drains, and so on.

4550. *Mr. Guntlake*: If that be so it does tie the thing to local authorities and their finances. We have the point from Dr. Monro that the whole of the local authority service is a vast depressed area, and a smaller proportion of the net taxable income is going into that particular object than was the case, so the outlook for preventive medicine seems to be pretty poor. That is your contention?—Yes. In fact though we are local authority employees we work more with general practitioners and hospitals than ever before.

4551. *Sir David Hughes Parry*: I wonder if I may ask one question on the Scots memorandum. It is on page 950, under the word "administration". You are obviously pressing a point there. Would you like to state your point? I am not quite certain whether I have got it. Will you place it in opposition to the argument which has been placed that the doctor ought to be paid more because he has got what is described as clinical responsibility for the patient, and that is why he should be paid more than a member of some other profession where that responsibility for life and death does not occur? That has been pressed again and again on us. You are pressing the other side, if I may put it.—*Dr. Monro*: I think the point I want to make is this; I attend to the administration of certain Acts, orders and regulations in the course of my duties. I am chosen as the administrator for that purpose because I have medical skill in the particular brand of medical training. These Acts and orders which I administer relate in fact to the medical needs of people or groups of people. In fact I am really arguing that in the case of the medical officer of health there is no essential difference between clinical medicine and administrative medicine. Does that answer the point?

4552. Yes. In effect you are doing both?—Yes.

4553. *Chairman*: It has been put to us by almost everybody that has appeared before us that their particular body has special reasons why they should be specially rewarded. For instance, the general practitioner says there is this question of night work,

which I suppose does not apply to medical officers of health as much or as often as to the general practitioner dealing with maternity cases frequently. Is that so, or not?—It depends upon what the person feels about odd cases—infectious cases. They have a bad habit of ringing up after midnight, Sir.

4554. You answer them on the telephone and turn over!—*Dr. Chalke*: The medical officer of health is always on duty.—*Dr. Cookson*: From experience over a good many years now the amount of additional out of hours work in a larger department—I was formerly in a smaller one—is less, and also even in a smaller department it did decrease with the start of the National Health Service. I have done a good deal of general practice in my day, and I do not think that I had any less night work as a medical officer of health than as a general practitioner when I started, but it is less now.

4555. You see you probably know, Dr. Monro, that the medical officers of boarding schools get a reduced capitation fee for two reasons, and one is because they are not on duty for the whole of the population at any time. Are there certain responsibilities that do not come your way?—I would make this point, that the medical officer of health is expected to know the answer, and give it over the telephone. The clinician is at least entitled to examine his patient first.—*Sir Selwyn Selwyn-Clarke*: I would say too that the medical officer of health has a lot of other duties, for example public health education, which he has out of hours, lecturing to voluntary organisations, and others. He also, as has been pointed out, may be called out in connection with infectious disease, poliomyelitis and what not, and he may have a whole series of queries sent to him in connection with, for example, a Windscale incident, the hazards of radiation. He may have to advise where to put a person, an old person who needs hostel accommodation, or home accommodation. He will have very much more work if Parliament agrees to implement the recommendations of the Royal Commission on Mental Illness and Mental Deficiency. I would like to make the point that the M.O.H. is not a 9 till 5 officer. He is, as the President of the Society pointed out, a man who

may be called upon at any moment. I have personal knowledge of members of our Society working all through the weekend over some serious outbreak of infectious disease in the area.

4556. I was rather anxious to get the degree of it. I know the fact is, that as in many other jobs, it does happen that you have an extreme amount of work under pressure and responsibility from time to time, but from the way it has been put to us by the general practitioner we are told that they have more of that than the M.O.H. Is that right?—*Dr. Tilley*: It must be abundantly plain to the members of the Commission that the medical officer of health is not likely to be called out of bed as often as the man with a large practice, but if you make that comparison we make the comparison also that your medical officer of health in my opinion is as likely to be called out of bed on the same number of occasions as the consultant bacteriologist or pathologist.—*Dr. Hughes*: I would rather like to stress the fact that there is quite a lot of this out of hours work, so to speak, and my impression is that it is growing with one thing and another. Certainly in the last few years I find myself getting busier and busier and taking more work home—not having to get out in the middle of the night, but doing it in late hours.

4557. May I put just one further question on this for relativity? Do I take it from what you say about recruitment, that if by any chance the rest of the medical profession were to get an increase in their pay, for one reason and another, and you did not, the recruitment to your branch would fall off?—*Dr. Chalke*: Yes, Sir, undoubtedly.

4558. But in fact you are really on the whole saying that you ought to catch up?—Yes.

Chairman: The difference is something that will emerge more clearly when we have the real facts.

4559. *Sir David Hughes Parry*: May I add, Sir, and, if I understand your argument, irrespective of whether there is any general increase in local government salaries to non-medical men. I took it that was your line of argument?—Yes.

4560 *Chairman*: If there happened to be a general increase to local authority non-medical men you would not like to be left out?—No, in other words in presenting our case this morning, we are altruistic in this as an academic body. All we are concerned with is improvement in recruitment and the standard of public health work.

4561. Are there any points that you feel we have not covered adequately bearing in mind all the time that we are not entitled to make any recommendations at all as to what your remuneration should be? We are trying to get a general picture.—*Sir Selwyn Selwyn-Clarke*: One point I should like to make—perhaps I shall be criticised for making it—I would like to mention the

point that the Prime Minister did at one period say that the question of including the public health medical officers in the terms of reference was being considered. I submit the implication is that the Prime Minister and his advisers did feel that the public health medical officers had reason to be dissatisfied with their present status.

4562. I think you must make your own interpretation of what the Prime Minister and his advisers were thinking. I cannot comment on that. Then I think that is all. And now we will have a few words with the Association of County Medical Officers of Health.—*Dr. Chalke*: Thank you very much indeed.

(The witnesses withdrew)

Royal Commission on Doctors' and Dentists' Remuneration

THE ASSOCIATION OF COUNTY MEDICAL OFFICERS OF HEALTH OF ENGLAND AND WALES

1. The membership of the Association of County Medical Officers includes all County Medical Officers of England and Wales, and whilst it is understood that doctors employed by local authorities are not amongst those for whom the Royal Commission have been asked to recommend levels of remuneration, this memorandum is submitted on the basis that County Medical Officers are amongst other members of the medical profession on whose remuneration evidence will be received. The Association is submitting this memorandum of evidence because it wishes to draw attention to certain matters concerning the remuneration of County Medical Officers which it believes are not widely appreciated. Taking expenditure of money as a measure of the resources in manpower and the materials deployed in a service and the number of medical staff as an index of the extent of responsibilities exercised, evidence is given later concerning certain representative counties showing the extent of change as between 1938 and 1956—largely in 1945 and 1948. Up till 1948 the remuneration of County Medical Officers was based on the recommendations of the Askwith Committee, first set up in 1929, but on the introduction of the National Health Service this function was undertaken by Committee "C" of the Whitley Councils for the Health Services (Great Britain). The consequence can best be expressed by a statement published in the County Councils Gazette of March, 1956, appearing in a report of a conference of representatives of local authority associations and the London County Council held to discuss a variety of matters concerning negotiating machinery and national awards:—

"It seems clear now, particularly since the recent Award of the Industrial Court giving to medical officers the same salary increases as were agreed with chief officers of local authorities, that the salary structure of local authority medical officers is tied definitely to the salary structure of other chief officers of local authorities. The conditions of service of medical officers are almost identical and, indeed, the Staff Side of Committee "C" have not been slow in asking for the conditions of service of the A.P.T. Council and the Joint Negotiating Committee for Chief Officers to be applied to doctors as and when changes have taken place. In the view of the Conference, medical officers should take their place alongside their colleagues as local government officers in distinctively local government negotiating machinery."

With their responsibilities increased it is difficult to establish any logical reason for their remuneration having been dealt with by the Askwith Committee on the basis of comparison with other members of their profession and then after 1948 on the basis of comparison with other Chief Officers in local government who have no part in the National Health Service and who are responsible for the administration and management of services that can be clearly identified as belonging to local government only with practically no association with similar professional activities elsewhere.

II. The Association wishes to place on record the fact that it finds it difficult to understand why the situation arises that the remuneration of County Medical Officers is not being directly considered because the terms of reference of the Commission refer to doctors taking any part in the National Health Service and, unlike any other branch of local government, Local Health Authorities' services provided under Part III of the National Health Service Act are beyond question an integral part of the national services provided under this Act.

Paragraph 4 of the Commission's statement on the 12th April, 1957, seems completely at variance with the terms of reference, which have never been amended. It is clear that Medical Officers of Health employed by County District Councils are not included and the point occurs to the Association that these officers have been confused with Medical Officers of Health to Local Health Authorities.

It will be widely known that in the organisation and management of Local Health Authorities' services, successive Ministers of Health and successive authoritative bodies such as the Guillebaud Committee have repeatedly urged the necessity for the closest possible integration of services as between the three main branches provided under Parts II, III and IV of the Act. The inclusion of County Medical Officers in medical committees associated with Regional Hospital Boards, Hospital Management Committees and Executive Councils is evidence of their share in the services. Since the management of County Council health services under Part III of the National Health Service Act is directed by County Medical Officers, it is ironical that the need for integration should be continually urged by successive Ministers of Health, yet those who must direct its practical application have, for a review of remuneration at least, apparently no part in the National Health Service.

III. Whilst the Association only wishes to offer evidence in respect of the remuneration of County Medical Officers, it is necessary to emphasise that they are doctors responsible for the management and direction of an essential part of the National Health Service; though they are not wholly engaged in seeing patients and are partly, or wholly, occupied in administration, the latter being an essential factor in the Health Service. The doctor's administrative acts are informed and directed by his medical and public health knowledge and experience in a way which is impossible for a lay administrator. Every County Medical Officer must be a registered medical practitioner, which means that he has followed the same training as general practitioners and specialists. In addition, he is obliged also to acquire a Diploma in Public Health or Degree in Sanitary Science and an additional qualification is frequently held. Certain of the statements concerning preventive medicine in the preliminary memorandum of evidence submitted to the Commission by the British Medical Association make clear the importance of services for which County Medical Officers are responsible. Thus:

Para. 84—"Doctors maintained and improved the health and efficiency of the working labour forces. . . . The Health Service is an investment—particularly in respect of the improvement in the health of children".

Para. 107—"The first concerns of medicine are maintenance of health, prevention of illness, restoration of the sick".

Para. 136—"The Consultant has "considerable responsibility for advising on [hospital] administration on matters of policy and development".

The Association realises the dangers of taking statements out of context, but considers it justifiable to use these sentences as a striking illustration of, and indeed as tributes to, the importance of the kind of activities for which County Medical Officers are responsible.

IV. In the same memorandum the British Medical Association stresses the need to maintain adequate recruitment (Paras. 47 and 91) and remarks on the late age of entry to pension schemes (Para. 93). Both of these conditions apply forcibly to the County Medical Officers and the first is of paramount importance.

Local Authority Services suffer competition from the opportunities, conditions of service and rates of remuneration in the various spheres of medical employment. The Association is convinced that the present condition of local government service is not attractive to young medical practitioners and that as a consequence there will be difficulty in the future in finding enough people of capacity to occupy senior administrative appointments where heavy responsibilities now exist.

The local government services provided under the National Health Service Act, although a separate entity, are themselves an integral part of the National Health Service. All pleas for closer integration and closer association of services must be nullified if the two parts of the service almost entirely engaged in clinical work are, as at present, far more attractive to medical practitioners than the third.

The Association is greatly concerned lest, as a result of the Commission's finding, this position should be made worse. The avoidance of sickness in childhood and the proper care of the aged and sick at home, and well devised health education, are worth a great deal to the community in terms of saving and the prevention of human suffering and distress. It is false economy not to give remuneration commensurate with that of other branches of the profession to those who provide the medical and administrative knowledge, and carry the day to day responsibility for the workings of these services.

V. It is appropriate to refer to the interchange of letters that took place following an interview between the Chairman of the Council of the British Medical Association and the Minister of Health on the 26th April, 1957. In the penultimate paragraphs of the Minister's reply he said—

"Finally, I have thought, as you asked—about the position of the public health medical officers. I cannot add anything of substance to what I said in my letter of the 17th April on this, but let me repeat that I am sure that any settlement for others, following the Commission's report, could not fail to be taken into account considering the position of these officers, and any claim through the normal machinery would, of necessity, be considered in the light of the report and of any settlement subsequent to it".

VI. The present position arises from the operation of the existing normal machinery of negotiating medical officers of health salaries. With all respect to the Minister, the Association has doubts whether his belief could be borne out in practice if, as the Minister appears to suggest, the existing Whitley Council machinery for determining the salaries of Medical Officers of Health still continues to be used. The Minister of Health is not represented on Whitley Committee C, the negotiating body for the determination of salaries and conditions of service for Medical Officers of Health. Indeed, the salaries of these Medical Officers of Health are derived wholly from rate-borne funds and are not eligible for government grants under the present individual grant system. The British Medical Association representing the medical staff employed in local government service, irrespective of whether they are engaged on National Health Service work or not, has consistently argued in Whitley Committee C that the remuneration of Medical Officers in local government should be based upon the remuneration in other branches of the profession, but the Management Side has held the view that the salaries of County Medical Officers should be related to those paid elsewhere in the local government service.

VII. Two main awards have been made to Medical Officers of Health since 1948 and both derive from findings of Industrial Courts, since agreement could not be reached in Whitley Committee C. On both occasions the Award of the Industrial Court resulted, so far as Medical Officers of Health are concerned, in a scale of salaries being applied on the same basis as applies to other chief officers of the local government service, and the Association believes it to be incontrovertible that the Awards of the Industrial Courts, as part of the Whitley Council negotiating machinery, represent a tacit acceptance of the view of the Management Side.

VIII. The grounds for the Association's doubts will, therefore, be appreciated since it would seem to follow that if the tenor of the Whitley Council machinery for County Medical Officers has, as the result of two Industrial Court Awards, been to relate their remuneration and conditions of service to those applicable to other chief officers in the service of the County Councils, any financial settlement applicable to general practitioners and hospital staff would have no more bearing in the future than it has in the past in dealing with Local Authority medical staffs. Indeed, on the present basis of Whitley Committee C procedure, the Minister's opinion quoted above is tantamount to saying that the remunerations of chief officers in local government service would need reconsideration on the basis of any settlement that might be made for the majority of the medical profession.

IX. As a matter of history it should be recalled that up to 1948 the remuneration of Medical Officers of Health, and indeed of other Medical Officers employed in the local government service, was based on the recommendation of a Committee presided over by Lord Askwith, which was set up in 1929. This Committee based its recommendations not on the level of salaries obtaining at that time or subsequently in local government service generally, but on the remuneration which might properly be paid for whole-time Medical Officers in local government service. The recommendations were eventually accepted by a large majority of local authorities and in the opinion of the Association were successful in attracting and retaining in the local government service competent and well qualified medical men and women.

It is well to recall that the Committee under the Chairmanship of Lord Askwith was not set up without difficulty and it was the Minister of Health himself who played a great part in bringing together the various bodies who eventually came to agree with him. At a meeting on the 25th April, 1928, when the creation of the Committee was under discussion, the Minister said to the representatives of local authorities:—

"The interest of the Ministry of Health in this matter lay in the maintenance of an efficient standard of public health service. It was not to support the B.M.A. as such. The Ministry had a further interest—to secure that due economy should be exercised in local government. Therefore, it might be put this way, that the Ministry desired to see the lowest salaries paid that are compatible with the maintenance of an efficient public health service, but was an efficient public health service to be measured only by the efficiency of the Medical Officer in question? The answer to that must necessarily be in the negative because no Medical Officer of a county or district could adequately perform his or her duties, or maintain an efficient public health service, unless they were working in harmonious co-operation with other medical men in the district, and if there were antagonism between the Medical Officer and the general practitioners of the neighbourhood that must necessarily injure the efficiency of the public health service.

It could not be expected that things would always remain where they were 50 years ago, circumstances changed, times changed, conditions changed, and it was necessary to change with them. Nowadays, when rates of remuneration were settled—he was not speaking of public bodies in particular, but of industry or any other body—they were constantly settled by collective bargaining. Every Government since the National Health Insurance Act had had to deal with the medical profession in regard to remuneration under that Act, and throughout had had to deal with them collectively."

The Association would go further and say that in the experience of its members the salaries the Askwith Committee thought appropriate for County Medical Officers were, in general, higher than those paid to other chief officers in the local government service, and that it is true to say that in the majority of cases, after the Clerk of the County Council, the County Medical Officer was the best paid officer in the service of the Authority.

X. The members of the Association are concerned as to the consequences which they believe are arising from the methods whereby the remuneration of the County Medical Officers has been determined since 1948. They do not believe that the services provided by Local Authorities under Part III of the National Health Service

Act and the allied School Health Service provided under the Education Act of 1944, can be maintained at full efficiency and integrated closely with other branches of the National Health Service on the assumption that in a National Health Service maintained wholly from public funds there can be two grades of medical practitioner, one engaged largely in clinical medicine and the other engaged mainly in the organisation, management and direction of large-scale health services and regarded and paid as local government officers who have received medical training. The local government service can, and does, offer facilities for training in post solicitors, treasurers, engineers and architects but it cannot train medical practitioners, who must spend a considerable number of years in medical schools and, when working in a local health authority's service, must do so in close harmony and association with their professional brethren, whose remuneration is almost entirely now paid from public funds.

XI. The following table gives some statistics concerning the duties and responsibilities of certain County Medical Officers, the basis of comparison being as between the years 1938-39 and 1957-58 :—

			County A	County B	County C	County D	
Total Population	...	...	1938	1,385,600	749,900	302,600	108,660
			1956	1,601,000	902,200	364,600	127,400
Population for Maternity and Child Welfare Services	1938	...	477,410	442,750	262,813	82,770	
	1956	...	1,601,000	902,200	364,600	127,400	
Population for School Health	1938	...	692,800	474,900	272,230	82,770	
	1956	...	1,601,000	902,200	364,600	127,400	
<i>Health Department Staffs:</i>							
Total Whole-time	...	...	1938-9	362	195	182	24
			1957	1,704	1,029	341	179
Total Part-time	...	...	1938-9	77	169	—	—
			1957	1,825	776	358	124
Total Medical Staff, whole-time	...	...	1938-9	30	11	12	4
			1957	51	21	5	4
Women Medical Officers, whole-time	...	...	1938-9	6	2	3	1
			1957	35	13	3	3
Whole-time Medical Officers possessing the Diploma in Public Health	...	...	1938-9	16	7	4	1
			1957	13	5	3	2
Gross Expenditure on Health Services	...	...	1938-9	£407,696	£218,062	£87,106	£36,515
			1957-8	£2,503,740	£1,274,985	£582,330	£182,947
<i>Annual Salaries of Chief Officers of County Council</i>							
County Medical Officer	...	...	1938-9	£1,600— £1,750	£1,350— £1,500	£1,600	£800— £1,000
			1957-8	£3,180— £3,705	£3,025— £3,390	£2,710— £2,975	£2,070— £2,340
County Treasurer	...	...	1938-9	£1,700 (no scale)	£1,250— £1,500	£1,000— £1,300	£950
			1957-8	£3,180— £3,705	£3,075— £3,390	£2,760— £3,025	£1,995— £2,225
County Education Officer	...	...	1938-9	£1,500— £1,750	£1,250— £1,500	£1,500 (no scale)	£850
			1957-8	£3,180— £3,705	£3,075— £3,390	£2,710— £2,975	£1,995— £2,225

			County A	County B	County C	County D
County Surveyor	...	1938-9	£1,500 (no scale)	£1,250— £1,500	£1,300 (no scale)	£950
		1957-8	£3,180— £3,705	£3,075— £3,390	£2,710— £2,975	£1,995— £2,225
County Architect	...	1938-9	£1,500— £1,600	£1,300	Part-time Architect employed with retaining fee on a per cent. basis	£550
		1957-8	£3,180— £3,705	£2,605— £2,865	£2,340— £2,710	£1,995— £2,225

The differences in the populations of the Maternity and Child Welfare and School Health Service Areas are due to the fact that under the Education Act, 1944, and the National Health Service Act, 1946, those County District Councils responsible for these functions transferred their duties to the County Councils.

Attention is called—

- (1) To the increase in the number of whole-time female medical officers, which is due to the difficulty in recruiting men. Many of the women are married and, while appreciating that their valuable services alone enable the work to be maintained, because of their domestic commitments and the absence of the Diploma in Public Health the great majority of them have no intention of accepting the higher posts in the local government service.
- (2) The difference in the number of whole-time Medical Officers possessing the Diploma in Public Health. Nothing could show more clearly that the number of those who have this qualification, and are therefore eligible for promotion to appointments as County Medical Officers, has sharply declined in proportion to the number employed and the Association is concerned as to the prospects of future selection for the highest posts, where this qualification is essential, in the medical services of County Councils.

XII. The purpose of this evidence is to set out certain matters in relation to the duties and responsibilities that devolve upon County Medical Officers of Health in England and Wales. It is appreciated that the Commission will be using remuneration standards obtained in many professional fields for the purpose of comparison in discharging the main responsibilities laid upon them in their terms of reference. The Association considers that so far as the present salary position of County Medical Officers is concerned the former basis of comparison no longer exists as between them and their senior colleagues engaged in the fields of general practice and hospital work. Prior to 1948 the County Medical Officer in the local government service was not paid on a basis that was linked with other chief officers. In general, the remuneration that was paid to County Medical Officers was based upon recommendations of the Askwith Committee and those recommendations had no regard to the rates payable to other professional officers in the local government service. The Association has no doubt that in making its recommendation the Askwith Committee took into account the fact that County Medical Officers, like other medical officers in local government service, had benefits of superannuation, sick pay and paid holidays that did not apply to general practitioners and the majority of medical staff working in voluntary hospitals. Two great changes have taken place since 1948; the first is that many of the benefits such as superannuation and sick pay now apply far more widely and the second is that the remuneration of County Medical Officers has, by the operation of Whitley Council machinery, become tied to the salary structure of other chief officers in the local government service. The Association would, therefore, wish to place on record its opinion that any deductions which might be drawn by comparisons as between the remuneration

received by County Medical Officers and their professional colleagues working in other branches of the National Health Service would be fallacious. The Association considers the continuance of the present Whitley Council arrangements whereby the chief medical officers of County Councils have their basis of remuneration tied to that of other chief officers is, in the long run, inimical to the proper functioning of the National Health Service because it is futile to believe that, in the final analysis, recruitment for higher medical posts in one branch of the medical service can be compared with the recruitment to branches of other local government services.

XIII. Reference has been made to the then Minister of Health's statement to the representatives of local authorities when the Askwith Committee was being formed in 1928 and the Association believes that the final note of this memorandum should be to repeat that what the Minister said then is just as true now. "No medical officer of a County or a District can adequately perform his, or her, duties or maintain an efficient health service unless he is working in harmonious co-operation with other medical men in the district." There cannot be harmonious co-operation between members of the medical profession if members of one section in the National Health Service are regarded, for remuneration purposes, by their employers not as medical men but as local government officers with medical training.

Examination of Witnesses

DR. A. ELLIOTT

DR. J. S. COCKSON

DR. C. D. L. LYCETT

DR. G. RAMAGE

on behalf of the Association of County Medical Officers of England and Wales, *called and examined*.

4563. *Chairman*: Now you have listened to the previous evidence?—
Dr. Elliott: Yes.

4564. And we have I imagine covered a very great deal of the ground that is of interest to you, is that so?—Yes, Sir, quite a lot of it is common ground. Of course the point of the Association of County Medical Officers is that it includes all the county medical officers in England and Wales, all of whom are engaged in National Health Service work. All the county medical officers are engaged in National Health Service work, although the purpose of their appointment was required by other legislation. We have touched on the point where we say the whole of our remuneration is at present borne by the rate funds. Some of our county-district colleagues are not employed in the National Health Service as such.

4565. You are employed in the National Health Service and that is one particular reason why you would have hoped that you would have been within our terms of reference?—We would have hoped so. We realise that we are

not. 90 per cent of our work is connected with school health and National Health Service work, and the other 10 per cent is in relation to general medical duties, some arising out of other legislation, and some arising out of medical functions relating to our county staffs.

4566. Now on the particular points then that you would wish to make, you give us some very interesting figures on recruitment, which is one of the subjects that seems to us to be most important. Are you having the same kind of difficulties as your colleagues, or is it not so marked?—We have not the same kind of difficulties. In my view—and I have been in the local authority services for nearly 25 years—we can only manage to maintain our services by recruiting women, mainly married women. I am not in any way denigrating their services, but I think we made the point that it is a common experience in counties that we are maintaining our service by employing people who for domestic and other reasons do not wish to seek promotion on the preventive side. This does not make us feel happy about the future administration of local authority services.

4567. Do you find when there are vacancies to be filled, senior posts, that there are not many people apply for them?—I think, Sir, without a doubt that what was said by the Society is true. Two months ago we advertised a post for what I would call a beginning administrative assistant on my central staff. There is my deputy, three senior assistant specialists and we wanted one below. Now I recall the same post being advertised 20 years before the war started, and then there were 42 applicants and out of a short list of five four have done extremely well since. On this occasion there were ten applicants, two or whom only were worthy of interview, both were in their fifties and neither was suitable because they are older than all the rest of us. We have not been able to fill that post. It is not easy at the present moment, in county councils at least, to find people who have followed the public health service. Clearly we can make it a career on promotion for people who eventually come out at the top, but the stream is not as broad as it was.—*Dr. Ramage*: I agree with that. Also as it is easier for people now to obtain posts, unfortunately there is not the same urge on them to go through the long process of acquiring experience which was described by our colleagues.

4568. Here is perhaps something we did not touch on. To what extent, Dr. Elliott, do medical officers of health when they have reached the senior status as a M.O.H. tend to stay in the same place regardless of the fact that after a very few years they reach the salary ceiling for the post? To what extent do they move on to bigger, and therefore rather more highly paid posts? That may apply more in the towns than in the counties.—*Dr. Elliott*: We can only speak, and would only wish to speak, on this matter for the counties.

4569. People would go from the county to a town and vice versa?—Not so much. Since the war I recall only one county medical officer who has come from a town. All the others come from counties, either small counties or from largish counties where they were deputies.

4570. Why is that? I am rather surprised to hear that there is this marked line of differentiation so that on the whole there is not much flow between

the counties and boroughs.—*Dr. Ramage*: I think there is more movement at the next lower level of appointment. I can cite myself, for instance; I came from a county borough to my present authority as deputy, and I think that is the experience of a number of authorities. Their deputies may be recruited more widely, but as the administration of the department and other aspects of the work are considerably different in the counties, when it comes to the appointment at the ceiling they tend to take the person who has had an active part in the administration of the county.—*Dr. Lycett*: I think the answer is also in the small number of authorities with large populations, and therefore larger salary scales. Speaking as a medical officer of a medium-sized county, in fact there are very few authorities that offer any real financial inducement owing to the small number of large authorities and to the ways in which the authorities concerned have interpreted this proviso of discretion where there is over 600,000 population.

4571. I am sorry, I have not quite got that point.—It was brought out I think during the evidence of the Society of Medical Officers of Health that authorities with populations of over 600,000 had discretion as to the scales they applied to medical officers of health. Clearly, if they applied their discretion fairly largely there would be scales for the post much above those of the medium authorities, and more incentive to move for promotion. As it is there is not a great deal in it to make up for the cost of moving, and one thing and another.

4572. I think on the figures that you give in your paragraph XI for county medical officers on the whole three out of four of them would seem to be receiving incomes right up to the over 600,000 class. That is right, is it not?—*Dr. Elliott*: But, Sir, A and B are at discretion.—*Dr. Ramage*: There are a number of counties with populations over 600,000 which have decided that the rate of 400,000 to 600,000 should not be exceeded.

4573. It would mean that just as the borough medical officer from a borough of over 600,000 probably does not apply for any job as a county medical officer, similarly most county medical officers do not really go except to your biggest towns, would that also be true? Once

you are within one branch or other you stay there?—*Dr. Elliott*: I think that is true. One naturally wishes to stay in a particular branch. Most have started at a fairly early age. If you are in the county you go on for the county, but then you do get applicants for special jobs in the county and county boroughs. An appointments committee of a county borough seeking a medical officer of health would I think rather be inclined to go for a man who had been with a county borough, and the same would apply to the county. The county medical officer in Hampshire appointed recently came from Bournemouth, but by and large I think that is true.

We really are not putting to you our view on salary and fixing of salaries. We realise the point that you are not in that sense the Industrial Disputes Tribunal or the Industrial Court. I think what we want really to say with considerable emphasis, is that the National Health Service is a tripod. There are three branches. It is a comprehensive service. The young practitioner, that is, the doctor in his late twenties, in the case of the hospital service, and in the case of the general practitioner field, knows he is going into those fields, he knows he is going to be employed and remunerated as a professional man, as a doctor. When he comes to the third branch of the service there his remuneration is based upon the fact that he is a local government officer first and a doctor second. It is clear therefore that for the young man who had not up to that period had any contact with local government, who has been almost entirely brought up in the hospital field, because that is where his training takes place, the weight is against him to go in for the field where it is made quite plain that he is a local government officer, and not a professional officer which previously he has been treated as.

4574. Is that a new feature, or was it exactly the same in the old days?—No, Sir, it is entirely new since 1948. In fact it did not really apply until the first Industrial Court Award of October 1950. From 1929 until 1948, and until 1950 when we had the carry-over, doctors in the local government service, whether employed in hospitals, mental hospitals or general hospitals, whether

employed in the field, were dealt with as doctors. The scales, as we have endeavoured to point out in our memorandum, had no regard to what was paid elsewhere in local government, and it is a point we want to emphasise again. You have already had it, but we are quite unable to see why there should be a link between the salaries of doctors in local government and other non-medical people. It is a matter of administrative convenience that certain services are administered by the elected body, but there is no community of interest between the other county officers and the county medical officer. They are not recruited from the same field. It could well have happened, as in the case of the executive councils in 1948, that the National Health Service Act had set up separate public health boards independent of County Councils and it could not then have been argued that the salaries of doctors employed by public health boards to carry out Part III services should be linked to local government. If they had been surely the hospital services should have been linked to local government too. We have taken the view that it is only a matter of administrative convenience that the Part III health services are administered as part of local government and it does not mean there should be this link of salaries of chief officers.

4575. You do feel that in all there must be some relativity between all kinds of people, whether local government or private industry, or anywhere at all? There must be some sort of relationship between what different people are earning in their grade, and you cannot consider any particular group of people completely separately?—I am rather outside my terms of reference here, but can you make such a broad generalisation? It is a matter of the supply and demand in employment, and so on. What we want to say as an Association is this, that come what may we believe that in the future of the public health service all local government doctors should be treated as doctors throughout, that the position that arose when doctors were paid from public funds, by local authorities from 1929 to 1948 should still continue, and that there should be a separate negotiating machinery. While we naturally hope

that that would result in better payment, we still say we stand or fall by the machinery being established even though we be dealt with worse, because if we in the public health service came into the general field then we believe our recruitment problems would be greatly eased. Doctors would be treated as doctors in the National Health Service and not as local government officers first and doctors second.

4576. You come back to this very important question which seems quite basic about recruitment. The Society said to us that they had not got precise facts and figures but they have a strong general impression which I gather they have always had. Have you anything more definite?—We could make some enquiries. We have not obtained them, but there is a difficulty here at the moment. My own whole-time strength is 51, but we have nearly 200 part-time medical officers some of whom are married women who can only work part-time, others are general practitioners. But those numbers fluctuate very much, and at the present moment are extremely high due to the poliomyelitis vaccination programme. But it is sometimes the case that when one has to recruit whole-time staff, if you are not quite happy about the calibre of people available, you can postpone selection for the time being and use part-time staff. We have no difficulty at the moment; I have a waiting list of 140 people wishing to do part-time work for us. So that if it were found that at the moment there was no difficulty in recruitment it could well be because there is at the time you made the enquiry an ample supply of part-time staff which happened to be convenient at that time. What I think we are all agreed upon is that the public health service is not at the moment among the first choices of the young graduate after some years in hospital.

4577. You have given us one or two reasons as to why that should be so, and much of that seems to be perhaps for the profession to put right, to make it quite clear to the medical schools and in medical publications, and so forth, that on this tripod, as you referred to it, the three legs are equal. There is also, you would say, the question of remuneration?—I do not think there is any use quoting personal experiences. What is it that determines men or women in the first

flush of their professional life to go into a certain line? It may be economic, they wish to have further training which they can or cannot afford to take. It may be family reasons. It may be some experience from their teachers. I do not think it is possible to take a young medical graduate educated in freedom and individualism and suggest he should follow some particular line because it happened to be for the public good. If one has trained for clinical medicine one would naturally wish to follow one's bent, and that would be one's first choice. There are people who come along with the intention always of doing clinical work or social work, may be in this country or abroad. If you are not very strong in one or other direction, quite obviously not only remuneration is going to come in, but also the way in which you are regarded as a person, and if in local government you are not going to be regarded as a doctor first and as a local government officer second, but a local government officer first and a doctor second, we can understand why we come low in desirability.

4578. We asked this question about status of the Society, and I did not gather from their replies that their status in the local community was much different from that of other doctors. Would you in the counties take a rather different view?—This, Sir, again is not anything on which the Association can speak. I can only say what I think as a person, and my colleagues I am sure would put forward another view. I do not know what status is in this context. It has very little to do with pay. It depends upon the capacity of the man in relation to his professional colleagues. It relates to the advice his professional colleagues would get from him. I think it is probably appreciated from what has been said this morning that we have to be fully knowledgeable on an enormous range of medical subjects from poliomyelitis vaccination to appearing in court as authorities on epilepsy and appeals on driving licences. It is our capacity in medicine which determines our status, and not our remuneration, and therefore if the local authority are going to recruit people who can cover a wide field of medicine we come back to the point that they are doctors first; it is not recruitment of local government officers with medical training. That is my personal opinion.

4579. *Sir David Hughes Parry*: It may be that you are taking rather a narrow view, because after all you are only considering recruitment from the time that the man has qualified. Those who go into medicine, those who go into the law, those who become engineers—in other words, those who become the chief engineer, the town clerk, and so on, they are all drawn from the same community, are they not? It has got to be effective at that stage.—I do not quite follow your point. Surely we want to recruit between the ages of 25 and 35.

4580. I am going back a little further to recruitment from the schools to the medical profession, and there may well be an opportunity even at that early stage for people to go in for what they call public service. I am wondering whether more ought not to be done at the medical schools to inform the students who are qualified as doctors to know of the possibilities of the public health service.—*Dr. Ramage*: That would be a very good thing, but I would like to refer to this question of status, to the point I mentioned a little while ago about people now being able to enter the local authority service with less experience than formerly. If it becomes known, as it is from time to time, that a fairly high proportion of the doctors in local authority service have had a limited experience in other fields, then they cannot be regarded in quite the same way by their colleagues. The older generation, and I am sorry to say we here fall into that now, were obliged to take a series, not only of higher qualifications, but a series of hospital jobs as our colleagues from the Society mentioned, and therefore we believe we enjoy a certain amount of esteem by our colleagues which greatly helps our work. We feel that position is rather endangered by what has been happening since 1948. If that has any relationship to status that is how I would look at it.

4581. *Chairman*: On this particular matter the question of status and pay is to some extent linked, and the figures you give in paragraph XI would seem to show that the increases that have been enjoyed by the county medical officers since 1938 are quite considerable. On the whole they are in the region of double, sometimes a bit more, but round about that.—*Dr. Elliott*: About 225 per cent.

4582. Which is not very far from what has happened in other branches of your profession.—First of all these are county medical officers. These are gross figures. I am not suggesting anything on the other sides of the profession in relation to part-time and general practice expenses, but I think one would generally think that was a material advantage when you are quoting net figures in relation to general practitioners.

4583. I am simply talking of the percentage increase since before the war.—The second point is this, that it is by no means comparable, is it, with the change in the value of money over the last 20 years. The third point is we would ask the Commission to look at the change in responsibility. We are not really comparing like with like, because from 1938 considerable additional duties have been put on us. But, Sir, I do want to make the point again that we are not submitting these figures to you as a form of salary claim.

4584. I realise that.—We put them forward for comparison with our professional colleagues in local government to show that in fact the parity, the comparisons which have gone before, the relationship between us and our colleagues in local government did not obtain until 1950, that is the date of the first Industrial Court Award. That is the reason.

Chairman: I think that point is quite clear.

4585. *Mr. Bonham-Carter*: That award, and subsequent awards, have been, I take it, related to the cost of living, or the change in the value of money, call it what you will? They have been amended to recognise that sort of change, is that correct?—No. The first Industrial Court Award was a result of the agreed reference to the Court by the Whitley Council 'C'. Briefly the Staff Side of Whitley Council 'C' in 1950 argued that doctors in the public health service generally should be treated as doctors and not related to other local government officers. The Management Side, the Local Authority Associations Side, argued that the time had now arrived that all medical officers should be treated as local government officers, and they wished to relate the salaries of chief medical officers, to the salary of chief officers elsewhere. That issue was put forward solely in relation to

the arguments of two sides, and the Industrial Court decided in favour of the Management Side. The second Industrial Court Award was concerned with cost of living, but the same battle was fought over again with the same result. The principle established in 1950 has not been disturbed, and, of course, the trade union question of reference to the Industrial Disputes Tribunal cannot arise. The situation that we have outlined here whereby since 1950 this tie-up has been between the doctor and the other local government chief officers was not the case from 1929 to 1950.

4586. *Chairman*: Now on a somewhat different point, have you any idea as to the average age at which somebody will achieve the status of county medical officer? I mean in present circumstances. I am not looking back to the past.—There are only 62 counties, 63 counting the L.C.C., which usually counts separately, although Dr. Scott is a member of our Association. It so much depends on the mortality rate, or the retirement rate of existing county medical officers. Frequently the deputy is appointed. It is so fortuitous, I do not think there can be any generalisation.

4587. We have had some figures about the age at which people will achieve consultant status, and so forth, and I am wondering whether in fact most people will achieve full county medical officer status by, for instance, 40 or 50 or not?—*Dr. Ramage*: It would be a lucky man who achieved his chief post at the age of 40. It has happened, but usually it is about 40 plus.

4588. That is the sort of age?—I think if we take the L.C.C. we would have to say it would be well over 50, but that is perhaps rather exceptional.

4589. *Sir Hugh Watson*: Quite outside this point and separately by itself, is there any interchange between Scotland and England of county medical officers of health?—*Dr. Elliott*: Practically none.—*Dr. Ramage*: I think it is one way.—*Dr. Elliott*: I cannot recall any appointment having been made of county medical officers from Scotland. In a number of counties medical officers are Scots having started their public health career there.

I would not like the Commission to take entirely the point that you must be

at least 40 before you become a county medical officer. I would say the answer is broadly correct. I do not think there is much chance after 50. The authority would look for a younger man.

4590. *Chairman*: I was trying to get an approximate relationship between the age at which people normally tend to become consultants, which varies, and that at which they tend to become county medical officers. It is a bit different, but not very much different?—The man who got it at 40 plus would think he was fortunate.

4591. *Sir David Hughes Parry*: I take it the competition for the higher posts is still very keen?—Yes, Sir.

4592. One has to try to look at the structure as well, because we have to look over the whole period. I was taking County A in your table and they had in 1938, 16, but they now have 13 whole time medical officers. How many of those are aspiring to be chief medical officer of health?—I think you have read the wrong figures. At the moment we have 51 whole-time medical officers, as opposed to 30 before the war. Taking those in possession of the Diploma in Public Health it was 16 then and 13 now. The point in putting the figures in about the D.P.H. is that only those officers are eligible to become deputies or principals in counties.

4593. That is why I chose them.—Out of that total number, you must relate it to the total, many of those are expecting to stay as they are.

4594. I am looking at those who are really fully qualified to be considered. How many of those can expect to be chief medical officer of health?—County A is my own county, of course.

4595. I did not know that.—*Dr. Ramage*: I think it is true that those who have got their Diploma in Public Health and who have decided to make public health their career, necessarily have a better prospect of the senior post. But I come back to the point again—and I would not like to criticise these men who come in particularly—that it is true that they get the post now with less experience than formerly.—*Dr. Cookson*: Can I make a point here from the point of view of the smaller counties? We have spoken of the counties A, B and C. If you turn to those in county D, I think the effect of the pyramid that we were speaking of

this morning is even more marked, because although one does not want to make much of the differentiation between the counties A, B, C and D, we do see there a great deal of difference in the remuneration between those in comparable counties D, to the other branches of the profession. If we could take just one example, that in 1938 a county D employed four medical officers more or less of that particular grade, and now they employ one; the other three have gone into other branches of medicine, and there their remuneration is that of consultants. So one has the difficulty of status and remuneration in counties D perhaps rather more marked than in the other ones. Now there are 18 county Ds with a population below 150,000, roughly a third of your total of your 62 counties. There are quite a number of county Ds and very few county As.

4596. *Chairman*: The county D rates before the war were fairly low. They have gone up quite sharply, as have the salary increases.—If we are to consider ourselves as doctors, I would compare myself with the other three doctors who were in county D before the war who are doing similar work now to what they were doing then, and are now paid as consultants with the status of consultants, which is very considerably in excess of the figures which have been given under county D. The status of the county medical officer of the county D if it were in any way connected with remuneration must have dropped substantially.—*Dr. Elliott*: I think Dr. Cookson is probably referring to the position of the old tuberculosis officer who became chest physician in 1948. It did so happen that, dealt with under the old Askwith Agreement, one officer's salary overnight was trebled by changing from one branch of the National Health Service to the other; by going from the local authority service to the public service his salary was trebled overnight.—*Dr. Cookson*: May I add on that that the same applies to the medical superintendent of the mental hospital, and the same applies to the medical superintendent of a general hospital; it is not just the chest physician and the tuberculosis doctor. So far as county D is concerned there were four senior medical officers who were employed in 1938 to 1939; three are now consultants and one is remunerated with the same status as the other chief officers

of the local authority. That applies in county D, but does also apply in 17 other counties.

4597. *Mr. Bonham-Carter*: All the witnesses we have heard this morning obviously feel very strongly and deeply about this thing, and therefore there is one last question I want to put about it, this link between the M.O.H. and the other local authority officers. Does that arrangement preclude the doctors' remuneration being on any occasion looked at by itself with a view to making sure that the normal law of supply and demand is being applied?—*Dr. Elliott*: First of all, Sir, of course any chief officer in local government can have a salary scale fixed from a range. There is discretion, as you know, according to the population, so it is theoretically possible for the county medical officer, or for the county treasurer for that matter, to have a different salary, and this appears clear on the basis of the law of supply and demand. If you ask me personally whether local authorities proceed on that basis, in my view they do not.—*Dr. Ramage*: Yes, I should agree with that. The local authorities have worked out this case very forcibly at the Industrial Court, and we feel that they reached by administrative convenience, I might even say by conclave, the classifying of all their heads of departments. I think we find it hard to say in the years 1929 to 1950 that their machinery worked badly just because the medical officer received a little more than the other officers. It was the case in my own county. I first came as deputy in 1940 and succeeded in 1946, and there was a differential in salary there, but the service seemed to work perfectly satisfactorily.

4598. Your argument then is that if they reached a point that there was such a shortage of applicants for the post of county medical officer they would still be so hidebound that they would not adjust the salary accordingly; they are bound by this Industrial Court?—That is the impression one has from the force of the range of arguments that they put forward.—*Dr. Elliott*: At the present moment there is no shortage of county medical officers. All we are saying is that you have, of course, three grades, principal, deputy and senior assistant, and it is our senior assistants where our troubles are coming. We cannot recruit

the men we want, and our field of recruitment is not as wide as it was 20 years ago.

4599. *Chairman*: I think it was put to us by Dr. Tilley, who is a county medical officer, that one of the important differences was that before the war, yours was the only branch of the medical profession that qualified for pension and superannuation, and that now other branches come into it and that that is a difficulty of recruitment. Would you go all the way with Dr. Tilley on that?—No, Sir, I would not. One has to take superannuation into account, but I do not think a young man of 25 or 26 attaches all that importance to his pension at the age of 65, and I am sure that women do not attach all that importance to it, because I presume they hope they are going to get married, and the pension does not matter. We believe, again coming back to the same point, and you must be tired of hearing it, that from 1929 up to 1948 practically the whole of the whole-time salaried medical profession were in local government service, either outside or inside the hospitals, but in local government service. Now the State has become the paymaster and there is a difference between the three branches of the service in the attitude of the paymaster to the person

who receives the pay. In two cases, in two branches of the service the payment is made to the doctors as doctors, and in the other one it is not, they are secondly doctors.—*Dr. Ramage*: I think if I may comment on that, we do not want to be drawn too far on this question of salaries, but we wish to be doctors come what may, whether up or down. When we make a comparison of doctors with people in local authority work before the war and make the comparison now, the fact that the other doctors may receive the advantages of superannuation and so on should be borne in mind. In reality the doctors in local government prior to the war were better off than appeared from just looking straight at their salaries, and that advantage has gone.

4600. I do not think I have any more questions. Do you feel you have made that point sufficiently?—I think we have made it, thank you very much.

4601. I rather understand you want to be thought of as doctors! (*Laughter.*) Then I think that concludes the meeting unless you have any other point?—*Dr. Elliott*: We wish to thank the Commission very much for hearing us separately. We do very much appreciate it.

(The witnesses withdrew.)

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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

19

Nineteenth Day, Thursday, 15th May, 1958

WITNESSES

Medical Research Council

Committee of Vice-Chancellors and
Principals of the Universities of the
United Kingdom



LONDON

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Witnesses

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SIR HAROLD HIMSWORTH, K.C.B., F.R.S., M.D., M.B., F.R.C.P., } Pages 982-1008
M.R.C.S. } Questions 4602-4690

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Questions 4691-4809

MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

NINETEENTH DAY

Thursday, 15th May, 1958

SIR HARRY PILKINGTON (*Chairman*)

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

MR. I. D. MCINTOSH, M.A.

SIR DAVID HUGHES PARRY, Q.C.

PROFESSOR JOHN JEWKES, C.B.E.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

Explanatory Note by the Royal Commission

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence to all representative medical and other interested organisations.

ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

- (i) The quality and quantity of recruits (a) offering themselves and (b) accepted for training as medical students.
- (ii) The quantity and quality of newly qualified doctors.
- (iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.
- (iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).
- (v) The position and prospects of a newly qualified doctor.
- (vi) Any trend to excessive resort to certain branches of the profession at the cost of others.
- (vii) The relative advantages and disadvantages, financial and otherwise, of service as:—
 - (a) a principal in single-handed general practice,
 - (b) a partner in general practice,
 - (c) a whole-time consultant in the National Health Service,
 - (d) a part-time consultant with the maximum number of sessions,
 - (e) a part-time consultant with only a few sessions,
 - (f) a Senior Hospital Medical Officer,
 - (g) a doctor in any other sort of practice or employment.

- (viii) The difficulties encountered by members of the registrar grades.
- (ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.
- (x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.
- (xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.
- (xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service.
- (xiii) Any anomalies in the methods of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume.
- (xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.
- (xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.
- (xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.
- (xvii) Special considerations of which account ought to be taken in discussions of medical remuneration.
- (xviii) Specific proposals for medical remuneration.
- (xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.
- (xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.
- (xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

MEMORANDUM FROM MEDICAL RESEARCH COUNCIL

Abstract

A. In organising for the present and future needs of medicine, it should be recognised that the concern is not with a single discipline, but with a series of interrelated subjects, all of which must be adequately provided for as each is indispensable to the final practical outcome. To this end, the system of remuneration of those engaged in the service of medicine—and particularly in medical research where the medicine of the future is taking shape—should be such as to impose no artificial obstacle to the natural distribution of the available talent between its different branches as need and opportunity develop.

The Medical Research Council, as the body primarily responsible for medical research in this country, feel that the present system of remuneration imposes such obstacles, and that these, by their continued operation, are likely to have an increasingly deleterious effect upon the development of medicine in this country.

B. The basic remuneration of consultants and of research workers in all branches of medicine is approximately the same, but, in certain branches, workers receive additional remuneration in the form of a Distinction Award. The total remuneration of these latter can thereby be raised to almost double that of the former.

C. Were this differentiation related to the developing needs of medicine or to the distinction of the workers concerned, its inevitable influence upon the distribution of the available effort and talent might be justified. But it is not. Thus out of the 64 medical research workers now in post who are Fellows of the Royal Society, 54 are

ineligible for the higher rate of remuneration; of the four living British Nobel Prize-winners in medicine (including one who was awarded the prize jointly for the introduction of penicillin) none are, or, if in post, would have been, eligible. Further, as all branches of medicine merge imperceptibly into each other, there is no clear and indisputable point in the nature of the work at which the present gross differences in remuneration could be imposed without creating (as they have done) disturbing anomalies.

D. The Medical Research Council are not opposed to the system of Distinction Awards in principle; but what they must oppose is the restriction of eligibility for such awards to a particular section of medicine to the neglect of its other branches. They feel, therefore, that earnest consideration should be given to the possibility of extending eligibility for Distinction Awards to all workers in the field of medical research. In terms of numbers the problem is small; in principle it has already been partly solved in Northern Ireland.

ROYAL COMMISSION ON DOCTORS AND DENTISTS REMUNERATION

Memorandum from Medical Research Council

REMUNERATION AND THE DEVELOPMENT OF MEDICINE THE EFFECTS OF THE DISTINCTION AWARD SYSTEM

1. During the last hundred years, medical knowledge has advanced more than in any other period of history. Inevitably, in the process, it has become increasingly complex and the natural result has been increasing specialisation and the extension of interest into ever widening fields of contiguous knowledge. This trend will continue. In organising for the present and future needs of medicine it is, therefore, necessary to recognise that we are concerned, not with a single discipline, but with a series of interrelated studies, each indispensable to the final practical outcome. Thus, even when attention is specifically turned to that part of medicine which is directly concerned with the care of the sick, the larger structure of modern medicine needs to be kept in mind so that suitable provision is made for each of its components to make its own essential contribution.

2. Adjustments of and additions to medical organisation are particularly necessary at the growing edge of medical knowledge, that is, in the research field; and it is here that the full complexity of modern medicine is most apparent. Today, behind any new measure which finds its expression in policy or practice lie many diverse contributions, not all of which are such that their essential nature, or even their existence, is readily appreciated. Perhaps no single event has more transformed medical practice than the discovery of antibiotics; yet the introduction of penicillin into clinical medicine was made possible only by the work of pathologists, bacteriologists, biochemists, pharmacologists, toxicologists and organic chemists. Similarly, our present understanding of many illnesses and their rational management is based upon physiology and biochemistry; radiotherapy is completely dependent on medical physics and radiobiology; the control of malaria rests upon the contributions of entomologists, toxicologists and chemotherapists. These examples could be multiplied, but they suffice to show that both the progress of medicine and the efficiency ultimately attainable in practice are today largely dependent upon the maintenance and development of a wide-ranging organisation of men with interlocking and complementary activities.

Any system of organisation which failed to provide for this, or placed obstacles in the way of its development, would rightly give rise to grave concern. It is because the Medical Research Council, as the body primarily responsible for medical research in this country, feel that the present policy regarding remuneration of those engaged in the service of medicine threatens harm to medical research, that they have sought this opportunity of laying their views before the Royal Commission on Doctors' and Dentists' Remuneration. They particularly refer to one feature of the present scheme of remuneration, the system of Distinction Awards by which salaries in some branches are augmented far beyond those in others.

3. The ability to advance knowledge is not common and the total research talent available in the medical field will always be limited. The dependence of medicine for its development on research makes it all the more important to ensure that those capable of original investigation should be employed to the best effect. If the medical profession is so organised as to provide opportunities for research, the potential original investigator will naturally find his way into a research career; his strong desire to follow his own bent in advancing knowledge may even lead him to take up such a career at some financial disadvantage. If however the dice are too heavily loaded economically against the research worker, many will hesitate to accept what must be regarded as an unreasonable sacrifice of their own interests, and even more, the interests of their families. The restriction of eligibility for Distinction Awards to one section of those engaged in the service of medicine has had the result that men in some branches of medicine, and particularly in laboratory research, find themselves in receipt of little more than half the remuneration of those in other branches.

4. Inevitably, disparity in remuneration of this degree has led to discontent, particularly as all remuneration comes eventually from the same source, the public funds. Since medically qualified research workers are recruited from the same manpower pool as those aiming at consultant and specialist posts, the continued operation of the Distinction Award system in its present form is bound to hinder recruitment to certain essential branches of medicine, and so ultimately, by leading to maldistribution of ability, to retard the advance of the whole. To appreciate the full effects of the anomalies created by this system, it is necessary to examine it in more detail.

Before doing this, however, it is necessary to draw attention to a point which might otherwise lead to misconception. The salary structure and grading of posts in the Medical Research Council's service are deliberately aligned to those in the Universities, and the same broad division of the subject into clinical, paraclinical and preclinical is followed by both. The Universities have, however, other responsibilities than the development of medicine, and it should not be thought that the Council, in presenting the matter as they know it, seek in any way to speak for the Universities.

The System of Distinction Awards

5. There are three grades of Distinction Award: Grade A, £2,500 per annum; Grade B, £1,500 per annum; Grade C, £500 per annum. Of those eligible, 4 per cent. receive Grade A awards; 10 per cent. Grade B, and 20 per cent. Grade C.

The Distinction Award is an item of remuneration, paid in addition to the basic salary, and counts equally with this for such purposes as pension.

To a person, judged eligible, who receives his basic salary from some source other than the National Health Service (such as a University Professor or Medical Research Council employee in certain branches of medicine) a Distinction Award is payable on the strength of an honorary contract with that Service.

The basic salaries of consultants in the N.H.S., and of academic and research workers in senior clinical posts, all have the same upper value, although progress up the scale for consultants and specialists is by automatic increments whilst progress up the academic and research scale is by separate acts of promotion. The basic salaries for non-clinical academic and research posts have a lower upper limit: £3,000 p.a. as against £3,250.

The proportion of a Distinction Award payable to any individual is determined on the basis of the actual time spent in the particular activities deemed to qualify him for such an award. Thus a whole-time employee in the N.H.S. receives the whole award; a part-time employee a corresponding fraction. From the start of the N.H.S. in July, 1948, until March, 1955, whole-time senior workers in the Universities, and with the Medical Research Council in certain branches, were paid the whole of an Award. Thereafter, they were paid a fraction according to the time spent in certain activities. This ranged from the whole Award if they spent 21 or more hours a week, to $\frac{3}{20}$ if less than $3\frac{1}{2}$ hours.

6. Distinction Awards are conferred by the Ministry of Health on the recommendation of a special national Committee which includes representatives of the Royal Colleges and Scottish Royal Corporations, and one representative each of the Universities and the Medical Research Council.

The grounds for conferring such an Award are: "... to recognise special contributions to medicine in the field of research or otherwise, exceptional ability or any outstanding professional work (other than administrative) . . ." (Report of the Interdepartmental Committee on the Remuneration of Consultants and Specialists, p. 11.).

7. The definition of the criterion for eligibility for a Distinction Award has not been easy. The terms of reference of the Interdepartmental Committee which made the original recommendation necessarily limited them to considering only a section of those engaged in the service of medicine: "... registered medical practitioners engaged in the different branches of consultant or specialist practice in any publicly organised hospital or specialist service." Such services being concerned with the day-to-day care of patients, the recommendations were, understandably, interpreted as being restricted to those directly engaged in such work; that is, those who had what is called clinical responsibility.

It has, however, proved difficult to draw a line on this basis. Medicine is one and its different branches merge imperceptibly: the clinical subjects proper, such as internal medicine and surgery, merge into the so-called "paraclinical" subjects such as pathology, bacteriology and pathological chemistry, and these in turn into the "preclinical" subjects such as physiology, biochemistry and pharmacology. The result has been that, in practice, eligibility has been conceded to some, but not all, holders of certain paraclinical posts (and in one part of the country persons in preclinical posts as well), but has been denied to others engaged in similar work.

The Present Working of the Distinction Awards System

8. Of the considerations to be taken into account when making a recommendation for a Distinction Award, the first to be mentioned is "special contributions to medicine in the field of research".

To the best of our knowledge, this consideration has been given full weight by the national Committee recommending such awards, in so far as they were able to do so within the restrictions on eligibility to which reference has been made. But if attention is directed to the larger picture of medicine, the result is disquieting.

Taking as the whole scope of medicine the variety of studies comprised in the medical faculty of a University or supported by the Medical Research Council, the result is as follows:—

Of the 64 Fellows of the Royal Society engaged in such studies and at present in post, 54 are ineligible for Distinction Awards. Of the four living British Nobel Prizewinners in medicine (including one who received the award jointly for the introduction of penicillin), all are (or if in post would have been) ineligible.

9. Mention has been made (para. 6) of the difficulty of confining eligibility for Distinction Awards to those directly responsible for the day-to-day care of patients, so that, in practice, it has been conceded that some but not all holders of paraclinical posts should be eligible. This has led to disturbing anomalies.

The concession regarding holders of posts in paraclinical subjects has primarily depended upon the man's place of work. If he were working in an institution, such as a medical school, related to a hospital, it was usually found possible to arrange that he be made an honorary consultant to the hospital, and thus become eligible for a Distinction Award. If, however, he were working in an institution unrelated to a hospital, then, irrespective of the nature of his work, it was not possible to make such an arrangement and he remained ineligible.

This situation has led to considerable practical difficulty. In the case of the Medical Research Council, whose staff are placed in many different institutions, gross differences in remuneration may occur between different individuals which are related neither to the merit nor the nature of their work, but to where they happen to be placed. Instances have occurred in which it has proved impossible to transfer a man to a more responsible job, even when both are under the Council's direction, because to do so would have meant changing his place of work from one in which he was eligible to one in which he was ineligible for a Distinction Award.

10. Although the first Distinction Awards were paid retrospectively to July, 1948, the awards were actually made only in 1950. The seven years that have passed since then hardly allow time for the full effect on recruitment to the non-clinical branches of medicine to be felt. Further, the Medical Research Council are particularly handicapped in demonstrating this effect, for their staff is relatively small, its main expansion has occurred since the war, and recruitment to it is by invitation rather than advertisement. Nevertheless, in their oldest and largest Institute—the National Institute for Medical Research—the consequence is becoming apparent. For example, in the important Division of Physiology and Pharmacology in 1948-49, 6 out of its 7 members were medically qualified; now the corresponding figures are 4 out of 8. In the Division of Biochemistry there is only one medically qualified worker out of a total of 18.

To some extent this situation may reflect a drift of interest in research towards more clinical studies; but, even if this be so, it is all the more important not to accelerate artificially the depletion of the essential preclinical and paraclinical fields.

The effects of the Awards system on recruitment of junior staff will necessarily take time to become fully manifest; but before then a serious situation is likely to have developed at a more senior level. It is not usually until the middle thirties that a research worker acquires the experience and develops the powers required to fit him for a key post; and it is usually at that time the family responsibilities begin to press. The Council are well aware of the personal pressure which some of these valuable men are under to move to posts elsewhere which, although carrying less responsibility, would gain them eligibility for a Distinction Award. Up to the present the Council has been singularly fortunate in losing so few senior men from key posts on the Institute's staff; but this cannot be expected to continue, and in the cases in which it has occurred the difficulty of replacement has given an indication of the serious situation to be expected.

After a careful consideration of the position, the Director of the National Institute for Medical Research has felt bound to warn the Council that they are now facing a grave situation. The Council agree with him; for it is generally recognised that if medical research is to derive its chief inspiration from medical problems it must in all branches, including the paraclinical and preclinical, include among its workers a substantial proportion with medical qualifications.

Extension of the System of Distinction Awards

11. The Council are not opposed in principle to the system of Distinction Awards. They consider it in the best interests of medical progress that superior merit should receive larger remuneration. What they must oppose is the restriction of Distinction Awards to a section of medicine in such a way as to threaten the natural development of the whole and so to jeopardize continued progress. The Council feel, therefore, that earnest consideration should be given to the possibility of extending eligibility for Distinction Awards to all workers in the field of medical research.

This proposal is not new, but it has gained force with the passage of time. Various objections have been urged against it, and these need brief consideration.

Objections which have been raised to Extending the Awards System

12. It has been contended that, even when consideration is confined to the present restricted eligibility, the factors to be taken into account when making awards are

sufficiently complicated, and that to extend the system to cover the whole paraclinical and preclinical fields would make it unworkable.

Since 1948, in Northern Ireland, Distinction Awards have been available to holders of paraclinical and of preclinical posts if medically qualified.

13. It is said that it would be too expensive to extend the Awards system.

In 1955, the number of consultants and specialists in the N.H.S. eligible for Distinction Awards was 6,650. The total number of persons in the para- and pre-clinical departments of the Medical Research Council who would be sufficiently senior to be considered for such Awards, if the scheme were extended, is about 100.*

14. It has been claimed that the strain of responsibility involved in taking care of patients entitles those with such responsibility to receive substantially larger remuneration.

While respecting this view, we feel that it may be overstressed. The ability of a man to support any particular responsibility depends to a large extent on his training. A trained consultant who may have no hesitation in handling a medical emergency, might well shrink from the responsibility of passing as safe for issue a vaccine that is to be given to thousands of people. Further, the question of differences in responsibility between the eligible and the ineligible in the paraclinical field does not arise.

15. The most difficult question that has to be faced is whether persons working in the medical field who are not medically qualified should be eligible for Distinction Awards.

For many years now, medicine has required the help of men whose initial training was in other disciplines and, in the process, has changed them into a body of specialised workers peculiarly identified with its needs. Indeed, a substantial factor in its recent spectacular progress has been this assimilation of other disciplines and their modification to its own purposes. In some fields—for example in medical physics—only rarely could a medical man acquire the necessary depth of specialised knowledge. In others, the overlap with traditional medical knowledge is more marked; and in some complete interchange is possible.

Although the Council agree that the paraclinical and preclinical departments of medicine can very profitably, and indeed, must now include, a considerable body of non-medically qualified scientists, they are persuaded that these departments, in the interests of their continued orientation to medicine, need to include a substantial proportion of those with medical qualifications. Both are necessary; one is the complement of the other. Further, they would willingly accept a non-medically qualified scientist as head of a department of physiology or bacteriology, provided that not all such departments were so staffed. But it would clearly be impossible to alter the salary of such posts according to whether the particular occupant has or has not previously taken a medical degree. The only possible solution, when this matter was debated in relation to the basic salary, was to pay the rate for the job. At the level of posts of this seniority in research it is proven merit, not formal qualifications, that is decisive. This is the principle upon which the remuneration of the Council's own staff is constructed. It follows, therefore, that in their opinion, if the man's contributions to medicine would normally entitle them to consideration for a merit award, the fact that he has not previously taken a medical degree should not exclude him.

16. It is, therefore, the considered view of the Medical Research Council that, if the inequitable salary structure of medicine, arising from the present system of Distinction Awards, is allowed to continue, it cannot fail to have deleterious effects upon the development of medicine in this country. In their view, measures to remedy this situation, before its full effects have become evident, require urgent consideration. An essential feature of any such measure would be that it took

* [The corresponding number in all Universities would be, according to our information, about 300.]

account not merely of one section of medicine, but of medicine as a whole, by ensuring that the financial inducements in all branches were sufficiently similar to allow available ability to distribute itself according to natural need and interest. If a system of Distinction Awards is to be retained but the artificial effects of the present system removed, then there would seem no alternative but to extend eligibility for such awards to those in all the branches of medical research.

November, 1957.

ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

Evidence submitted by the Medically-qualified Staff of the National Institute for Medical Research (Medical Research Council) London

PART I

OUTLINE OF DISCREPANCY IN REMUNERATION

1. The terms of reference of the Royal Commission include a request that the remuneration of doctors within the National Health Service be compared with that of doctors in other fields. One such comparison, which brings out a gross discrepancy, is outlined below.

Personnel Involved

2. The group of doctors outside the National Health Service with which we are concerned in making this comparison, is a very small one, estimated at about 400 in all. The group includes senior lecturers, readers and professors in the preclinical teaching departments of the Universities together with those of equivalent seniority engaged in whole-time medical research, mainly with the Medical Research Council. These two broad categories are linked to form one coherent group because, at present, the M.R.C. salary scales are based upon the scales pertaining in corresponding University departments.

Status of Personnel in relation to N.H.S. consultants

3. To compare this group of 400 medically-qualified men and women with any particular group of doctors employed in the N.H.S. is difficult. We believe, however, that there are many points of close resemblance between this group and the consultant group in the N.H.S., such as:

- (a) entry to both is restricted to those of high academic achievement;
- (b) seniority in both is the result of a long period of postgraduate training and apprenticeship;
- (c) many members of both groups are concerned with the teaching of medical students. The similar responsibilities of the two groups for the continued production of an informed medical profession is thus clear;
- (d) both groups play an important part in advancing the frontiers of medical knowledge, the preclinical teacher and whole-time research worker in the laboratory, the consultant in the clinic.

4. We hold that neither group predominates in importance, either in teaching or in research; and that the two groups are recruited from the same raw material and are essentially equal in status, ability, qualifications and experience.

Remuneration of Personnel in relation to N.H.S. consultants

5. Notwithstanding the relative comparability of the two groups, there is, at the moment, a wide discrepancy in their financial rewards. This is best illustrated by the Table overleaf, which is based on the following considerations:—

(a) *Senior Research Worker or Preclinical University Teacher*

A typical senior research worker or preclinical University teacher may expect to be appointed as a senior lecturer or reader (or its equivalent in

whole-time research) at the age of about 35. He will earn a salary of about £1,700, which will rise by annual increments of £100 to some £2,200. He has no guarantee that he will rise above this salary. Indeed, any further increase will be contingent upon appointment to a Chair (or its equivalent in whole-time research). If the average age for appointment to a Chair (or its equivalent) is taken as 42, and we make the assumption, which is broadly correct, that at any one time one-third of the group of 400 occupy University Chairs or equivalent appointments, then the chances of our typical worker being appointed to such a post before retirement are somewhat less than 50 per cent.

(b) *Consultant*

A typical consultant may expect to be appointed at the age of about 38. He will receive a salary of approximately £2,600 which will rise by annual increments of £125 to £3,250. Once appointed a consultant, he is *certain* to reach this salary if he remains in the service. Furthermore, the maximum salary of £3,250 is by no means the maximum of his possible total remuneration since he has a very good chance of acquiring a distinction award. We have no information about the age distribution of consultants at the time they are given distinction awards. We have therefore made an assumption, which is not necessarily true but which seems not unlikely. We have assumed that, on the average, a distinction award (considering all grades together) is given to a man in mid-career. This implies that, since 34 per cent. of consultants are in receipt of distinction awards at any one time, the chances of our typical consultant acquiring an award before he retires are twice this, namely, 68 per cent. This two-fold increase will, of course, tend to be greater for "A" awards which are probably usually given to older men and less for "C" awards.

6. On the basis of these examples, we can calculate the probability of a typical member of each group attaining a final total remuneration (before he retires) of various amounts; the results of such calculations are given in Table I.

TABLE I

Total Remuneration*	Percentage chance of achieving such remuneration or better	
	Consultant	Senior Medically-Qualified Research Worker or Pre-clinical University teacher
£2,250	—	100
£3,000	—	50
£3,250	100	0
£3,750 (Salary + C award)	68	—
£4,500 (Salary + B award)	28	—
£5,500 (Salary + A award)	8	—

* Total remuneration takes no account of children's allowances (£50/child) payable by Universities and the Medical Research Council but not by the N.H.S.; nor of other fees and emoluments payable to consultants by the N.H.S. but not payable by the Universities or the Medical Research Council.

Patient Responsibility Differential

7. It seems clear that this disparity in total earning capacity cannot be dismissed as trivial. It is also evident that it does not reflect differences in basic ability. A difference in respect of patient responsibility is admitted, but cannot be held to justify a discrepancy of this magnitude. (The B.M.A. some time ago suggested a differential of 10 per cent. in respect of patient responsibility.)

Effect of Discrepancy on Pensions

8. Much of the difference in total earning power is, of course, only apparent in view of the toll taken by surtax on the larger salaries, and we have calculated typical figures for net income (see Table II). But the distinction awards count towards superannuation; pensions bear proportionately less tax; and the discrepancy in pension is therefore relatively greater. The figures given in Table II illustrate this, which is—we consider—an aspect to which too little attention has been paid in the past.

TABLE II
Effect of Distinction Awards on Net Incomes and Net Pensions

Remuneration	Gross Income (no children)	Net Income (2 children)	Per cent increase in net income due to award	Gross Pension	Net Pension (no children)	Per cent increase in net pension due to award	Per cent of group drawing net pension
Salary (Non-professorial)	2,250	1,775	—	1,125*	925	—	50
Salary (Professorial)	3,000	2,225	—	1,500*	1,175	—	50
Salary (Consultant)	3,250	2,375	—	1,625	1,250	—	32
Salary + C Award	3,750	2,600	10	1,875	1,425	14	40
Salary + B Award	4,500	2,950	24	2,250	1,650	32	20
Salary + A Award	5,500	3,325	40	2,750	1,950	56	8

* These figures are not based upon F.S.S.U. benefits which vary for each individual; but are calculations of the equivalent that would be obtained were the same scheme operated in the Universities and the Medical Research Council as in the National Health Service.

Effect of Discrepancy on recruitment and staffing

9. The effects of the discrepancy are, we believe, already apparent in the staffing of preclinical departments and of research establishments. There are two main effects:—

- (a) New graduates in medicine of high academic distinction are more attracted to the field of consultant practice than to preclinical teaching or research. It is thus increasingly difficult to recruit young medically qualified staff of suitably high calibre to preclinical teaching departments and to research institutions, and more and more scientists with no medical qualifications are being employed.

Since both teaching and research require, for maximum efficiency, a proper balance between medically and non-medically qualified staff, the failure to attract medical graduates to these fields is bound to affect adversely both teaching and research in this country.

- (b) Medically-qualified men and women with years of experience in preclinical departments are tempted to try to alter—perhaps only slightly—the direction of their research so as to enable them to transfer to clinical or paraclinical departments in view of the greater rewards there. This results in a loss of the very people, namely those about to take on the responsibilities of senior posts, on whom the future of the preclinical subjects most depend.

10. In addition to these direct results of the discrepancy, the relatively low remuneration in the preclinical departments is resulting in the loss of an increasing number of the most promising of younger workers to the U.S.A. and elsewhere. No doubt many factors extrinsic to the present argument are operating in this trend; we mention it only as a factor further aggravating the plight of the preclinical departments.

Recommendation

11. Since the Royal Commission is asked to consider the total remuneration of doctors in the N.H.S. in relation to that of doctors outside the service, we ask:—

that the Royal Commission note the discrepancy described above and emphasize its regrettable effects upon recruiting to preclinical teaching departments and to research institutions, and the inevitable decline in the standards of medical teaching and research that must result.

PART II

SUGGESTED USE OF HONORARY CONTRACTS WITH THE N.H.S. AS A MEANS OF REMOVING DISCREPANCY IN REMUNERATION

12. The terms of reference of the Royal Commission also include the making of recommendations about the remuneration of doctors within the N.H.S. One group of doctors within the N.H.S. is a group of honorary consultants, whose primary source of remuneration lies outside the N.H.S. We ask the Royal Commission to consider the possibility of increasing the number of such honorary contracts by widening the criteria of eligibility for them. Since the holding of an honorary contract as a consultant automatically confers eligibility for distinction awards, this method of rectifying the discrepancy described in Part I of this evidence could properly be used by the Royal Commission.

Distinction Awards and the Discrepancy

13. We recognise that the Royal Commission cannot make any recommendations affecting the salary scales of the Universities or the Medical Research Council. Nevertheless, since the distinction awards are the most important single factor in the discrepancy referred to in Part I of this evidence, it is clear that if distinction awards were payable to medically-qualified senior research workers and preclinical University teachers, a major step in eliminating the discrepancy would have been taken.

Honorary Contracts with the N.H.S.

14. Within the framework of the N.H.S. there exists the possibility of awarding honorary contracts as consultants to persons actually employed primarily by bodies other than the N.H.S. Persons holding such honorary contracts are quite evidently an integral part of the N.H.S. although they draw no salaries from the N.H.S. They accept responsibilities to the N.H.S. as well as privileges from it.

15. The criteria upon which the giving of an honorary contract have been based are not at all clear and in fact have varied in different geographical areas. Thus, to our knowledge, honorary contracts have been given to some preclinical University teachers and to some members of the staff of the Medical Research Council. In general, we understand that honorary contracts are not usually given unless there is patient responsibility, either direct in clinical departments or indirect in paraclinical departments. Nevertheless, exceptions even to this general rule do exist.

16. We understand that the responsibility for the giving of honorary contracts lies wholly with the N.H.S. and not at all with the Universities or with the Medical Research Council. We would therefore suggest that it lies with the Royal Commission to review the basis for awarding honorary contracts, with a view to extending the criteria of eligibility for holding them in such a way that senior staff in the pre-clinical departments can freely be given them.

Recommendation in regard to Honorary Contracts

17. We therefore ask:

that the Royal Commission recommend that the criteria of eligibility for holding honorary contracts as consultants in the N.H.S. be widened in such a way that all senior medically-qualified preclinical research workers and University teachers can be given them.

Distinction Awards for Preclinical Workers

18. The holding of an honorary contract as a consultant in the N.H.S. automatically confers eligibility for a distinction award. Were honorary contracts to be given to the small group of 400 doctors with whom we are here concerned, the additional cost of distinction awards to the N.H.S. would be less than 6 per cent. of the present total (since there are nearly 7,000 consultants already in the Service).

19. We do not consider that the present consultants should either lose or benefit from the extension in number of honorary contracts proposed above; nor do we consider that the existing Awards Committee is appropriate to select the recipients of awards in the new group.

Recommendation in Regard to Distinction Awards

20. We therefore ask:—

that the Royal Commission recommend that a separate sum be made available for the payment, through the N.H.S., of distinction awards to selected members of the group in the foregoing paragraph; the proportion and value of the awards to be the same as applies to the existing awards; but the selection to be carried out by a separate committee appropriate for the purpose and distinct from that responsible for nominating consultants.

This Document has been prepared and approved by the undersigned medically-qualified members of the National Institute for Medical Research (Medical Research Council) London.

S. M. HILTON.
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H. ELLIS LEWIS.
J. O'H. TOBIN.
F. HAWKING.
P. D'ARCY HART.
C. H. ANDREWES.
W. L. M. PERRY.

D. R. BANGHAM.
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A. C. ALLISON.
A. S. MCFARLANE.
S. COHEN.
R. J. W. REES.
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B. BALFOUR.
A. ISAACS.
JANET S. F. NIVEN.
P. H. A. SNEATH.
AUDREY U. SMITH.
B. M. WRIGHT.

Total medically-qualified staff 42

Signatures (two persons abroad) 38

Date: 20th February, 1958.

Examination of Witness

SIR HAROLD HIMSWORTH, on behalf of the Medical Research Council,

Called and Examined

4602. *Chairman*: Sir Harold, we are very grateful to you for coming here, and I hope we shall not need to be very long with you, because in the whole of our very wide range of problems you concentrate on one particular and isolated aspect. You probably do know that this is a public session and that anything you say is liable to be reported, and no doubt you will bear that in mind. —*Sir Harold Himsworth*: Yes, I understand that.

4603. We have asked Sir David Hughes Parry, whom I think you already know, to prepare most of the questions we want to ask you, but would you mind first,—since the memorandum which the M.R.C. have put in will be printed along with your evidence—giving us an outline of what the Medical Research Council is, how it is constructed and what are its functions, authority and so on?—*The Medical Research Council* is a body established under the Privy Council. There is a committee of medical research of the Privy Council, of which the Lord President is chairman, and it is to that committee of the Privy Council that the Medical Research Council is responsible. It consists of twelve members, of which three are elected in respect of their non-scientific qualifications, one of whom must be a member of the House of Lords, one of the Commons and one other distinguished person. The rest, the other nine, are scien-

tific members; they are appointed by this committee of the Privy Council, but the nomination of the scientific members is made by the Council itself after consultation with the President of the Royal Society. The remit of the M.R.C. has always been interpreted very widely. It is concerned not only with disease but with health and all the basic studies that go to the understanding of normal human life, as well as to pathological processes. It therefore ranges in its remit from studies like the structure of biological molecules, through chemistry, biochemistry, anatomy, physiology, bacteriology, and so on, into the clinical field, and includes studies in all the clinical specialties. It derives its money from two sources: far and away the major part is a grant in aid from the Government; but it also holds private funds left to it in the form of legacies, covenants and so on, which it is free to dispense. That is roughly its constitution.

4604. And how many people does it employ?—It employs directly on its staff, in the scientifically qualified staff, over 600—that is, directly under its own employ. With technicians, clinical staff, supporting staff and so on, we are getting well up to 2,500.

4605. And are they all whole-time employees?—Those I have mentioned, yes. A very small number are part-time; for instance, we might have a man who for half his time is positioned in the

National Health Service and the other part of his time is on our staff.

4606. *Sir David Hughes Parry*: When you say "qualified", you mean they are qualified medically?—No, I meant that they have a university degree and are what we call our scientific and medical staff; I was putting them both together.

4607. I wonder if you could give us an estimate of the numbers who are medically qualified among the 600 qualified?—Roughly just about two-thirds, 60 per cent. are non-medically qualified, but that includes of course, as is essential with medicine nowadays, a large number of juniors who are operating these highly complicated machines and methods of estimation which are necessary: for instance, a physician nowadays in many fields hardly seems to be able to function unless he has a chemist attached to him.

4608. Could I pursue this further? Are the 600 qualified people all working in one centre, or are they working at different centres?—We have only one large research institute, the National Institute for Medical Research, at Mill Hill, associated with a building at Hampstead. The vast majority are in what we call research units and groups. Most of those, in fact with one or two exceptions, are placed as guests either in teaching hospitals or universities, a few are in non-teaching hospitals; that is our main method of distribution. In addition we have a few people whom we call members of the external staff, who are solitary persons, that is, they are not in one of our departments; they may be operating in some field where the lone wolf is required. More often they are operating in a university department, because the professor has been very anxious not to lose them and he has not had the money to keep them on his staff, and he has asked us to help him out.

Sir David Hughes Parry: Thank you very much, that is of great interest to us.

4609. *Mr. Gunlake*: Is your field of activity confined to the United Kingdom, or does it extend to the Commonwealth or to foreign countries?—We have no geographical limitation. But for the purpose of this discussion I have confined

myself to the United Kingdom, although we have for instance a research unit in East Africa, one in West Africa, one in the Caribbean; we recently had one in Jordan, and we operated in Egypt, and we are now operating through the W.H.O. in Madras in India, and of course we have frequent contacts with the Dominions.

4610. *Chairman*: But those units are, as it were, units sent out from here?—Yes.

4611. And paid from here by the Council—from the Treasury? From your own funds?—From our own funds. Just to round off the picture in that field, we are responsible jointly with the Secretary of State for the Colonies for all medical research in colonial territories, and we have a joint committee, of which I am chairman, which has two pockets: one pocket is the M.R.C. budget, the other pocket is the Colonial Development and Welfare Fund. The bigger organisation is paid for by the Secretary of State but is still administered by this joint committee and scientifically directed by it. It is in fact part of a very large remit.

4612. As regards the medically qualified people, Sir Harold, would most of them be Members or Fellows of one of the Colleges, or would they only have taken the earlier degrees?—The situation varies with the subject. If they are in charge of a research unit which actually has the responsibility for the care of patients, then of course they must have the requisite high degrees. In medicine they must have the M.R.C.P. and the M.D., and in surgery they would have the M.S. and M.R.C.S. The M.R.C.Ps. seem to acquire considerable distinction and go up and get their F.R.C.Ps. and numerous lectureships, and so on. If they are in the para-clinical or pre-clinical fields, it is not obligatory to have these higher degrees; you will find in our units concerned with pathology, and so on, that they may have their M.D. without having their M.R.C.P., and in physiology you will find the same. So that it has roughly sorted itself out along the same lines as are required in practice. That happened before the introduction of the National Health Service, because one knew if one were putting a research unit down in a hospital, the Board of

Governors of the old days would say: "We want evidence that this man is competent to act as a full physician and take charge of the patients"; so that it did tend to sort itself out in that way. In other words, the man whose interests begin to move on to the side of looking after patients will take care that he gets one of these high degrees, so that there is no obstacle to his future promotion because somebody objects to his not having the requisite degrees.

4613. *Professor Jewkes*: Could I ask about the non-medically qualified members of the 600? You have mentioned chemists—I suppose there are physicists?—Physicists are very much in demand at this present time, and physical chemists. At one end you have the chemists, the physical chemists, who have not got medical degrees. Then you come into a kind of borderline where they merge, shall we say biochemistry and physiology, and even extending over into bacteriology. And here medical qualification is rather optional—I do not wish to mention anything in connection with the universities, because that is nothing to do with me, but perhaps if I might use an illustration in this field; if you look at the professors of physiology, you will see one who is medically qualified. When he goes he may be replaced by a non-medically qualified one. The same occurs in anatomy. This is the line where you can get an overlap, and that overlap is a very healthy one provided it does not go to either extreme. If the whole of this borderline field were staffed with non-medically qualified men, it is our feeling that it would lose direction. If it were staffed entirely with medical ones it would fail to be refreshed from the basic field.

4614. Moving from the overlapping area—chemists, physicists—zoologists I suppose are among the 600?—Not employed on our staff. I think we have tended to regard professional zoologists who are employed as falling rather more over to the side of the Agricultural Research Council. When there are zoologists doing work of interest to us, say in a university department, we will give them grants to help them, but we have not employed pure zoologists. We have got some people who have had zoological training who in the course of time have shifted their interests over into the medical field.

4615. *Statisticians?*—Statisticians certainly. One of our biggest units is under the honorary direction of Professor Bradford Hill—medical statistics, epidemiology—and he of course is not medically qualified.

4616. *Psychologists?*—Certainly.

4617. You seem to have nearly everything—philosophers?—I do not think so! I wonder if I might give you an example from my own field which shows the extent of this overlap? Recently in the press there has been a great deal of attention devoted to the poliomyelitis vaccine. That is potentially a dangerous vaccine. People have in mind the disaster that occurred in the States in 1955. It has to be tested and looked at exceedingly closely before it goes out. Now we do that testing, and—I may just explain, the M.R.C. does not take on routine, but in a very new subject when routine and research are so near together it may be necessary for us to carry the thing, because we are the only people who can. That is a very onerous responsibility, and it is carried out by our department of biological standards. The present head of that department is medically qualified; he is moving away shortly to a university Chair. He will be succeeded by a man who is his deputy at present, who is not medically qualified. That man will have the whole responsibility for passing poliomyelitis vaccine issued in this country. And I may say that neither of these men come within the merit award category.

4618. *Sir David Hughes Parry*: I think it would be useful if you would indicate to us the manner in which you recruit members of your qualified permanent staff. I believe that is our starting point.—It is very rare for us to advertise; it is nearly all done by invitation. We appoint say a director of one of our units—and a director is of professorial standard. He will go to the scientific societies, and so on, he will see the type of man with the interest he wants, he will approach him and sound him out, and if the man is willing to come then he comes to us. So our recruitment is on a personal and selective basis, as it must be in a thing like research, which depends so much on quality. And so far it has worked exceedingly well. I might just mention a point which is important, and that is

that, as is mentioned in our memorandum, we believe that the flow of people through our organisation back to the universities, and so on, is very healthy. In fact one of my great difficulties is to keep people, because they always get offered Chairs, particularly in the field of biochemistry. So that when they first come to us we give them quite short-term appointments—three, four, five years—we do not give permanent appointments. We differ from the Scientific Civil Service and all other research councils in that—until people are of proved merit and seniority, until, that is, they are roughly of senior lecturer or professorial status.

4619. There is no particular age at which you recruit?—No, there is no fixed age at all—you are talking about the scientific staff?

4620. The scientifically qualified staff.—Quite. But circumstances tend to make the age slightly different for the non-medically qualified and the medically qualified. The non-medically qualified man may come to us of course after getting his first degree, his B.Sc. The medically qualified man has a longer course and he is a few years later in coming to us. And if he is going over slightly on to the clinical side we are very anxious that he has some general clinical experience before he comes. So although you may get your B.Sc. men coming at 22, 23 or something like that, the medical ones I would say come three or four years later. But that is just the circumstances of the course.

4621. And that is the time at which it is most important that there should be this free flow?—I would have said it was important at all stages, because the number of people who can support a life of pure research is limited. At the beginning everybody thinks he can. I was talking to some people in I.C.I. the other day and they said that all the people they recruit ask for the research side for a start, but it is quite common for my people to come to me in their middle thirties and say: "You know, I thought I wanted nothing better than to do research twenty-four hours a day, but I do not really think I have got that intensity in me. I want something with a continuing activity that I can take pride in as well. I hate the thought of thinking at the end of twelve months that all my ideas have gone wrong and I have

nothing to show for it." You will find them inclining towards the academic side then, and, I would say, quite a number of them. If you look at the Chairs in this country that have been filled by people we have trained, I think we might very well claim that our National Institute is a nursery for professors.

4622. *Chairman*: Do you bring many people in from university Chairs?—Actually from Chairs that is very rare. They are fixed at that stage, just as the very senior people with us tend to be fixed, but in the sub-professorial levels there is a great deal of going backwards and forwards.

4623. When you say the very senior people you are thinking primarily of administrators?—No, of actual research people. There are some people who can have that flow of ideas and originality and can keep it right up to retiring age—it does not always go off at 40.

4624. *Sir David Hughes Parry*: I am trying to narrow the field for the flow. You say that it does not matter very much at the professorial stage. Does it matter at the readership stage? Have you recruited any readers from universities, or senior lecturers?—Yes, people like that have come over to us, certainly; some few remain permanently as heads of divisions, but some have come over rather at the level where they are wanting to follow intensively a piece of work. But there is this interlocking going on the whole time.

4625. Now we come to what you have said in your memorandum—we have been trying to get at it gradually. In your abstract, the last sentence of the first paragraph says: "To this end, the system of remuneration of those engaged in the service of medicine—and particularly in medical research where the medicine of the future is taking shape—should be such as to impose no artificial obstacle to the natural distribution of the available talent between its different branches as need and opportunity develop." I think we recognise the point. You only in fact mention one particular obstacle, the merit award. Reserving that for the time being, are there any others, before we come to that?—That is the major one. If I had not that to worry about I should be confident about medical research in this country in the future,

and that means the quality of British medicine.

4626. We proceed then I think to the consideration of this merit award or distinction award . . . —I should say "distinction award," I do not know why it came to be called merit award.

4627. You do not like the word "merit"?—I know what the word "distinction" means. I am not quite sure about "merit".

4628. Is not "distinction" also liable to cause a certain amount of unhappiness, as much as "merit"—to those who have not got it?—There are certain recognised criteria of distinction in the country, such as the Fellowship of the Royal Society.

4629. The question I would like to ask is this: in a salaried service, in which you are engaged, are you quite satisfied that a merit award or a distinction award would not cause a good deal of unhappiness and uneasiness among members of the staff, where some would have it and some would not?—I do not think so, because one of the privileges that we have been allowed to keep, and which is approved by our staff, is that the actual promotions within the basic scales are determined by merit. We have had discussions on this point. We have thus got the freedom to give accelerated promotion when we wish. I have had meetings with my staff from time to time, since I have been at the M.R.C., and they were quite clear in recognising that in a research organisation everything depends upon quality, therefore you must be able to recognise merit. So within the basic salary scales we can promote people, accelerate their promotion, and there is the recognition on the part of the staff of the importance of merit in a field like research.

4630. *Mr. Gunlake*: I would like to be quite clear about this. You say promotion is by merit—that means you have no fixed establishment?—We have no fixed establishment.

4631. If a man shows merit, you can push him up into a higher bracket whether there is a vacancy or not?—Yes, certainly; that is a privilege we have.

4632. *Chairman*: Who settles what the actual salary scales are?—The Treasury approve the salary scales.

4633. Which are related, are they, to the Scientific Civil Service?—No, they are related to the universities. We are told so to devise our salary scales that "employment with you is neither no less nor no more attractive than in the universities."

4634. *Professor Jewkes*: That gives you plenty of scope!—Yes. But, having fixed the scales, it is left to us.

4635. *Chairman*: To decide who fits in where?—Yes, and how many too, which is important.

4636. *Sir David Hughes Parry*: "In the universities" means with reference to the non-clinical or to the clinical teachers in the universities?—It means the corresponding department, clinical and pre-clinical.

4637. *Chairman*: Then are you not able if you wish to have some salaries that are the equivalent for instance of a professor's top salary at the university, plus a merit award?—Yes, when they are in the clinical field; and that is one of my great difficulties at this present time. Those members of the M.R.C. who are in control of clinical units do get these awards, and as they are distinguished people they get high awards. May I volunteer something at this stage which will illustrate the situation, and the reason for my Council's concern, I think more graphically than anything else? The Secretary of the Commission wrote to me before I came here and asked if I would get out figures to show the remuneration of the non-clinical members of our staff before the war in comparison with the clinical members, as compared with now. I have got these figures here and would just like to explain how they are derived. I said I was concerned primarily with merit awards. That is the ultimate incentive for a man—where he can look. I am not concerned with the lower ranks. What is the highest a man can attain to? I have therefore in compiling these figures taken the head men in our individual units and the head men of the major departments of the National Institute for Medical Research. Those are people roughly, most of them, of professorial status—some of the juniors you might call of Reader status. And these are the results. There are not many figures from before the war, but they are sufficient, because our main expansion

has occurred since then. I have taken ten year intervals: 1937, 1947—because that is the year before the N.H.S. came in—and 1957. I can give you the details afterwards, but if I give you them straight first, it brings out the point. In 1937 the average salary of the heads of our non-clinical departments was £1,310; the average salary of the heads of our clinical departments was £1,320. In 1947 the average salary of the heads of our non-clinical departments was £1,590; the average salary of the heads of our clinical departments was £1,680—that is a 6 per cent. difference, and it is explained by more junior people having been recruited. So up to 1947 there was equality in salary between all people we employed, irrespective of where they were situated and irrespective of the degree they might have taken a long time before. The situation in 1957—I took last year, because this year is not complete yet—is this: in the non-clinical the average salary is £2,720; in the clinical the average remuneration is £4,520—that is due to the merit award. As regards the range in salary, the top salary for a non-clinical man in 1957 was £2,850. The top remuneration being received by a clinical man was £5,350.

4638. *Professor Jewkes*: When you give the figure for the 1957 clinical, it is an average figure for the heads of your units who happen to be in clinical work?—Who are employed by us—because we have some units attached to universities—professors who are honorary directors—and I have not taken their salaries up because they are purely honorary. These are men who are employed by us.

4639. *Chairman*: I do not like to go into individual cases too much, but earlier on you mentioned a particular instance where you were shortly going to lose someone medically qualified, and as part of this valuable interchange it so happens that he will be succeeded by somebody who is not medically qualified. There will be about that sort of difference, therefore, will there . . . ?—No, because the man who has the responsibility of passing poliomyelitis vaccine, and the vaccine against tuberculosis and all the others in this country, is not entitled to achieve a distinction award.

4640. Even when he is medically qualified?—Yes.

4641. *Professor Jewkes*: Up to 1947, if there was this equality between clinical and non-clinical, did it mean that you found difficulty in getting people to act as head of your clinical units?—No.

4642. Would there not be a great difference between their earnings with you and their earnings if they went out as consultants or even as professors?—In this discussion I have assumed that you do not take into account what a man might make if he went out into private practice. My point was concerned with salaries, the salaries that are paid from Exchequer budgets; they may be out of different pockets but it is the same paymaster. The development of clinical research has come up very rapidly since the war, in this country, and we had not many clinical units in 1947. We had three before the war, that was all.

4643. How many have you now?—We have 40 all told, 40 units and research groups. In fact we have 68 units in being at this present time.

4644. *Chairman*: I just want to be quite certain—you would have had no way open to you under your present constitution and remit from the Lord President, or from the committee of the Privy Council, to have treated the poliomyelitis vaccine unit, for instance, in such a way that the head of that could have got something of the order of the £4,520, instead of £2,850?—Certainly not. It would not be accepted; it would not have a chance of being accepted.

4645. *Sir David Hughes Parry*: I have one other question, but I am keeping that for the time being in case my colleagues want to ask a question about the merit award. I want to ask later on about a memorandum submitted by the staff of the Medical Research Unit, to ask you if you have seen it?—I saw it yesterday.

4646. But we will reserve that for the time being.—The point that I was going to make bears upon this memorandum, the question of when the pressure begins to bear upon these men. I should dislike it to be thought that in medical research workers one is dealing with a peculiarly mercenary branch of medicine. One is not. Of all the branches of medicine that I have met, I think they perhaps have the strongest

sense of vocation. But in the representations which I have had, the thing which bulked rather larger in their personal representations was what was felt to be the slur on their prestige. There they were, employees of the same source, and yet one branch was felt to merit so much more than another. That was one of the points about it. The other was the question that was put to me rather well by a late professor of physiology, when he said: "Young men are often altruists; fiancés often say they are; mothers of young families are always realists, otherwise the human race would not have survived". The pressure is at the intermediate level, when it is still open for a man to change; and that is where the difficulties are, where the men are becoming key men. And I am anxious about it, not only because of losing them in this country but also of losing them abroad, particularly to North America. These men are pretty distinguished, and although one can never find out with any certainty the range of salaries in the posts in North America, I have made enquiries and I have been told by individual professors: "The only man who knows what my colleagues are getting is the Dean". They do not seem to be published with any certainty, particularly in the older universities. There is no question that these people are being given the most attractive offers, and quite a number of them are people whom this country cannot afford to lose. I am not having to worry about those offers in the clinical field, where the merit awards are payable, whereas I am acutely worried in the non-clinical field, where people are casting envious eyes upon our bacteriologists, our geneticists, our experts—and this is particularly important—our experts on the health aspect of nuclear power. Even those who are working on the diseases which come from radiation exposure, and so on, are not entitled to the merit award.

4647. That is why I was concentrating on the period of recruitment. I have an impression now from what you have said that it may very well be that the age at which you recruit the medically qualified may be a little higher than the age at which you recruit the non-medically qualified, is that so?—Yes, but no more than can be accounted for by the longer length of the course, and the fact

that to get your name on the medical register now you have to do a year's clinical work afterwards. It is no more than that, and I would not have said there was any significant difference between the two.

4648. I was trying to keep an eye on the period when the flow has got to be particularly open.—I had not really thought there was any particular difficulty there. It will happen naturally if there is no obstacle. But the other point I would like to make here is in comparing the relative remuneration in different branches of medicine. When a man is qualified there are several openings to him, there are several pathways that he can follow, without doing violence to his own interests in medicine; for instance, the cast of mind that makes a physiologist and makes a consultant physician is a very similar one. It is the same point of view and outlook, and when a man is qualified he can, without doing too much violence to his interests, switch from one which will lead him up to a salary with a merit award tacked on to it at one end, or go on to a line which has not got one at the other end. The point I was anxious to bring out is that this is not an artificial distortion of a man's interests at that stage. Any of them could foresee having quite an interesting life up some other path than the pre-clinical one; that is the point I am making. It is not that the choice before them is the pre-clinical or nothing. It is a genuine choice which one can make in that direction. One can see this shift occurring, and I am particularly perturbed about the operation of this influence, because it is one of the steadily operating factors which will not produce a crisis to jolt people to look at what is happening. We shall just wake up some morning and find that we have denuded these essential branches of medicine, and that will not be remedied overnight. My own feeling is that we are half way there. We have had ten years.

4649. *Chairman:* Sir Harold, in paragraph 8 of your memorandum you say: "Of the 64 Fellows of the Royal Society engaged in such studies and at present in post . . ." How did you arrive at this figure?—This figure can be altered about a little according to judgment. I took my Year Book of the Royal Society and I went through and marked every

Fellow who was engaged in activities which would qualify him for employment with the M.R.C. These are all the Fellows of the Royal Society who are engaged in medical subjects of any kind; they are not all with us.

4650. You said, and obviously it is true, that to be a Fellow of the Royal Society is a matter of great distinction, and you know that there are some 7,000 consultants entitled to and 34 per cent. of these getting merit awards now. Obviously most of those are not Fellows of the Royal Society, only a very small proportion, is that right?—In the Royal Society at present clinical medicine is very lightly represented. Of people in post, I think there are about eight or nine Fellows of the Royal Society—I would not be certain, I would have to check that—who would be entitled to a distinction award. I was omitting myself, because I was once a professor, and would have been entitled if still in post.

4651. You say there are these 64 Fellows of the Royal Society—of whom 54 would not be eligible for merit awards?—Yes.

4652. Those 54 are necessarily more distinguished than a great many of the 34 per cent.—a great many, I do not say all. Is that a fair assumption?—I would prefer not to answer that question as you put it. These men are distinguished, very distinguished, by the most stringent criteria applied in the advancement of knowledge on the scientific side in this country. They are recognised to be that. I would have said that those men are making essential contributions to the medical field, the type of contribution upon which the development of medicine is built and upon which the future quality of medicine in this country will depend. I would prefer to put it that way round.

4653. *Professor Jewkes:* To take up a point you raised a moment ago, Sir Harold: is it true that the pre-clinical side of medicine is more important now in relation to clinical than it was twenty or thirty years ago?—I think it is of increasing importance. If you would put the question "more important than it was twenty or thirty years ago", and allow me to escape from the invidious position of deciding which is the more important . . .

4654. No, please do not escape.—It is certainly more important, and certainly will become more and more important. Take a field like the treatment of cancer with radiotherapy; the quality of physics that has to be applied in order to use those machines on patients is very high, and it is a field of physics in itself, it is medical physics. The man starts as a qualified physicist in the field, but to become a master of it he has got to master the medical side. He is producing a subject of his own, with the net result that after he has been in that field for some time—and this is important—he is not qualified to go back into a physics department; he has ceased to be a pure physicist. So that is one of the important points with these non-medically qualified people. They come into medicine, and medicine changes them into something else, so that they are not able to go back to the basic pure chemistry or pure physics in which they were trained. Therefore medicine has the moral responsibility for them. It is undoubtedly the high quality of support that medicine is progressively getting from people in those fields that is sending it forward at the rate that it is at this present time. I gave some examples: we could never have had penicillin without that co-operation; all these new drugs, these anti-malarials and what have you, that are coming in, it is unthinkable that any practising doctor could produce those. It has to be from this co-operative work with these people. And in the one field with which I personally have to concern myself at this present time to a very great extent, that is the field of nuclear energy and all that it means to the human race from the point of view of the health of this generation, the health of workers in the plants, and the health of future generations, in that field you cannot move without the highest grade assistance—physicists, radiobiologists, and people of that kind, who are called medical physicists or health physicists, because they moved out of the physical field. I do not know if I have answered your question?

Professor Jewkes: Yes, thank you.

4655. *Chairman:* Going on from the point about changing around. In these two different spheres you have one very high ceiling and one very much lower. Does that affect the salaries and the scale that you can pay to the people within

those units further down?—No. The ceiling that we go up to—if I take the last year, 1957, they were both equal, £2,850; but we could pay £3,100 as a ceiling for the clinical. That is the reason why in 1957 there is a slight difference between the basic pay, because the ceilings were slightly different. Lower down it does not matter.

4656. It does not matter if you have somebody getting £5,350, and the man immediately under him will be very much further below him than the man under the one who is getting £2,850?—That depends, Sir. I am sorry, I slightly mis-took your question. There are really two parts in this. If one takes the basic salaries, they come up to ceilings that are a little different. Beneath those ceilings we just give the same basic salaries to either side, whether they have got medical degrees or not. It depends on their merit. When you get above that ceiling you get into the range of merit awards. Any man who has an honorary consultant post with the National Health Service is entitled to a merit award, and there may be more than one in a big clinical unit. They are the senior people, of course. So it might follow that the head of the unit has a merit award, and the one underneath him has one also. That is the position.

4657. Might it have followed that the head of the unit was not eligible for an award and the one underneath him was?—Not as things stand at this present time. I can think of one of our units in which that might conceivably arise—the director is not medical, and the man on the clinical side of the unit is clinical. I had not met that particular difficulty, but I could see it could arise; he might get a merit award whereas the director could not.*

4658. Yes. This Treasury formula which says that the Medical Research Council salaries should be "neither no less nor no more attractive than in the universities" is an important one. Is that common to other branches of the research activities, do you know?—No, it is unique to the Medical Research Council.

* Sir Harold Himsworth has since informed the Royal Commission that his answer to this requires correction. The answer should be "Yes, that situation has in fact just arisen and the one underneath has an award."

4659. When was it produced?—The actual formula I think was written round about 1948, but it had always been understood. You see, we are the oldest of the organisations, and we were established in that way.

4660. The formula dealt with what was already happening?—It was formulating what was practised.

4661. So that the announcement of the formula really was made in consultation with the Council? There was some consultation with the Medical Research Council, but at that time the question of merit awards had not obtruded itself very much?—No, since 1913 when we had started off, this had been the understanding.

4662. And generally speaking do you regard that as a reasonably flexible formula and approach?—I do, yes.

4663. Apart from this particular difficulty?—Apart from this particular difficulty.

4664. *Mr. Gunlake:* May I ask a question on paragraph 14 of your memorandum, Sir Harold? That is a paragraph which refers to the strain of responsibility, which is simultaneously important and difficult from the point of view of this Commission. It has been argued before us by those who carry the clinical care of patients that the strain which they bear of responsibility for human life, health and happiness, is something which is different in degree, and perhaps different in quality, from the responsibilities borne by members of other professions. Last week we had before us the medical officers of health, who stressed the responsibility which they carry for social or community medicine and preventive medicine. In your memorandum and again this morning you have referred to the quite clearly grave responsibilities carried by the head of the vaccines departments. And yet we have a sentence in this paragraph 14 which pulled me up short when I came to it, where you say: "The ability of a man to support any particular responsibility depends to a large extent on his training". I wonder if you could help us by enlarging a little on that? How far would you press that view?—May I say, before answering your question, that I was a physician, I am a physician, that I have been a consultant physician, and I was a Professor of Medicine at University College

Hospital and consultant physician on the staff there, and I carried this responsibility until I went to my present post, so I am talking now of my personal knowledge. And by responsibility I take it that people are meaning the anxiety inseparable from certain duties that they have to discharge. I do not wish to be sententious on this point, but the particular sentence you picked out comes from Xenophon. This argument occurred in one of the Socratic dialogues, where a young man came to Socrates saying that he had great ambitions to be a governor or a general, but he had not the self-confidence to do it, and then follows the famous argument of the helmsman on the ship, when the general is shaking with fright but the helmsman is standing at the helm—why? Because of his training. I am sorry to be sententious on that, but that argument has been thrashed out two thousand years ago.

4665. *Professor Jewkes*: There is at least one philosopher on the Medical Research Council, Sir Harold! (*Laughter*).—I think this is absolutely true: in the clinical field, you start as a medical student; after a few months you are allowed to put a needle into a vein, and you are covered with perspiration the first time you do it. Then this becomes routine, and you go a bit further and a bit further, and you start delivering babies, and steadily step by step this builds up and by the time you become a physician or a surgeon it is second nature. I am not saying one does not walk away and worry about it, but there are worries on the other side too. Since I have come to my present job I know that I am bothered when a new drug is being tried for the first time on a human being, even though I am not actually giving it. I have taken the responsibility, I have said that all the tests on animals show that this should be all right, but I must admit that I have heaved rather a sigh of relief when the first stage has been got over. I mentioned this particular instance of the man in charge of the poliomyelitis vaccine; there he has the knowledge that a disaster did occur in the States and people were paralysed and people were killed, and he has to take the responsibility of passing that vaccine for thousands of people. I think myself, on this question of responsibility, that the ability of a man to support any particular responsibility does depend to a large

extent on the training, and that there are responsibilities outside the clinical field which are as onerous as those within. And on the border line over which the merit awards spill, the so-called para-clinical field, there is certainly nothing to choose between those who are eligible and those who are not.

4666. *Mr. Gunlake*: If we were to add after the word "training" the words "experience, personality, and psychological and physiological state of health", do you think we would have improved on Xenophon?—Am I to draw the inference from your question that you think there is a kind of process of natural selection at work?

4667. I was questioning whether training alone answers this problem.—I think myself that it is a major factor. You can put in experience—training and experience—but in the medical training up to consultant, experiences are very deliberately graded, and of set purpose.

4668. *Professor Jewkes*: Sir Harold this is a more general question: the group of experts who are eligible for merit awards have a ring placed round them by the use of the word "clinical", and although as you have shown it is not as simple and straightforward as that, it sounds simple and straightforward. How would you define the rather different circle that you would like to create, so that people would accept this as fair and just?—You are asking me to go beyond my Council's brief now on this particular point. Naturally when they were considering this matter they also remembered the other half of the question about distinction awards which the Royal Commission put down on paper—alternative ways of dealing with them. But they were anxious to keep this to the principle, because there might be many and different ideas about ways and means. It would, I think everybody recognises, require redefinition. But anything I said on that would be purely personal.

4669. Perhaps I put the question badly, Mr. Chairman. What I was really trying to get at was this: you talk in terms of another 500 non-medically qualified experts whom you suggest should be eligible for merit awards?—I am being very proper and confining myself to the 100 in the employ of the M.R.C.

4670. All right, let us take the 100. How do you define them so that they can be distinguished from all the other scientists who exist in medical research and in the universities?—I would not like to put this forward as a definition I have produced, if one were putting up a scheme or something like that, but the thing which distinguishes those 100 people is that they are all engaged in research which is directed to medical ends.

4671. *Chairman*: Yes, but would you differentiate simply in the field of research? Would you differentiate between those who are very eminent in research directed to medical ends and those equally eminent in research directed to some other scientific end?—Do you mean within the medical field?

4672. No.—I think, Sir, that that is a question which takes me outside my remit.

4673. Yes, but all the same, Sir Harold, these people on the whole come out of the same sort of stratum of intelligence in the community; they have the same ideas about advancing knowledge and doing something really useful for posterity, and it is not only in the medical sphere. There may be many other spheres of activity in which research workers find themselves to some extent Government-paid, eventually by the Treasury, would you not think so?—I am afraid I have not quite got this—you mean people employed by the Department of Scientific and Industrial Research or the Agricultural Research Council?

Chairman: Yes.

4674. *Sir David Hughes Parry*: And the universities.—I was confining myself strictly to this field, because I was not empowered to go beyond it.

4675. *Chairman*: Yes, but one of the things that seems to cause some difficulty here is that there has been a separate category of people created since 1947, who are put in quite a different box?—Yes.

4676. Do you make it any easier for the community as a whole if you enlarge the category but still have a separate category for which only a small part of the community as a whole are eligible?

—There is no question at all that there is a very embarrassing problem here. All the scientific members of my Council are university professors, and they are therefore very well aware of this particular point. At present the line is drawn in the most arbitrary way, which is quite difficult I think to defend. The question that you are asking is: would it cause more trouble if it were drawn at the bottom of the medical faculty instead of down the middle of it, in a wavy line?

4677. Yes. The question is whether when one anomaly is got rid of it produces a lot more anomalies, or not.—That is a question which concerns other people; it is outside my remit. But what I was sticking strictly to here was a division drawn in the middle of medicine which was going to affect the quality of the whole structure of medicine in this country.

4678. I fully take the point, but you feel, I think, Sir Harold, that this difficulty has arisen partly at least because there was at the time of the Spens Report an artificial segregation of one part of the profession, that is right, is it?—That is what I think personally.

4679. One part was looked at in blinkers, and if we look at an enlarged view of one part of the community in blinkers it may not cure all the difficulties.—If it were enlarged to cover those engaged in medicine we would not be concerned about the future of medicine in the country.

4680. *Sir David Hughes Parry*: If the scope was shifted so as to cover all your men it would remove your embarrassment but it would create embarrassments elsewhere.—And it would also be salvation for some! Of course, their problems in their departments are pretty much the same as ours.

4681. *Professor Jewkes*: Could I take up an intermediate position as we are so anxious you should help us here, Sir Harold? Suppose there was a case where you were not employing but you were financing some chemist—a man, say, in a university. If you thought the work he was doing was a long shot but that it might have some importance, would you feel that sort of man ought to come into the circle and be eligible for a merit award?—No. We finance

in two ways, by employing the staff and by giving grants to people who are in the employ of others and universities. We give a large amount of money in that way and I would say for the kind of long shots where something might come off. We finance it on that basis but we do not regard those people as employed by us, or responsible. Now, if something new came out so that a new subject was emerging which was nearly medical, or could be made medical, such as, shall we say, biophysics—that was started by physicists who began to get near to the biologists—and there was no place for it at that time anywhere else, if we took that and developed it we would take those people into our own employ because the future would be too insecure for them otherwise. Here is a risk subject; somebody started it, but if it has to be developed we have to give them the security so that they can develop it. Then they would come on to our staff, but we should have to be satisfied that it was of medical relevance before we could justify the spending of public money.

4682. *Chairman*: Do you find a big difficulty from time to time with something that is just on the borderline. Do you have some hesitation in deciding whether it is in, or not?—Certainly, and there are frequent meetings between the Secretaries of the three research councils, the Nature Conservancy, or the Chairman of the U.G.C. and the Secretary of the Royal Society. We meet and compare notes, particularly the three Secretaries and the Chairman of the U.G.C. When it is a borderline case there is often a discussion as to which side it should be on—I say “often” although this sort of thing does not arise as frequently as you would think.

4683. I have not formed any idea as to its frequency but I suppose there are always a few marginal cases at any time, are there not?—There are a few marginal cases but, shall I say, less than one would suspect—that is what I should have said.

4684. *Sir David Hughes Parry*: I was going to ask whether you have seen this memorandum from the medically-qualified staff of the National Institute of Research?—I just saw it yesterday. In fact, the Secretary mentioned it to me over the telephone and sent me a copy.

4685. This may be the only opportunity we may have and we ought to give you the opportunity if you want to do so to make any comment on any matter in it.—I knew that the members of the National Institute, which is one of our Institutes, had applied to send in written evidence and, of course, they have a perfect right to do so on the matter. I looked this through and they have tackled the thing in rather a different way but the substance of it is very similar to what we say.

4686. So you do not desire to say anything else then?—No, I do not desire to say anything on the matter at all. Perhaps I might just make one point that they mention and which we have not made in our memorandum, and that is the question which the senior people notice, the question of pension. A person who is entitled to a merit award, a person in our employ or employed by a university, who is entitled to a merit award, that merit award is pensionable under the F.S.S.U. system so that it makes quite a difference to their retiring pension and we omitted to mention that.

4687. A difference in the pension as well as in the salary you mean?—Yes, combined together.

4688. *Chairman*: We shall probably be printing their evidence at the same time as yours, I suspect. Broadly, you do think the general impression from the figures they quote is in accordance with yours?—Yes, the general impression from the figures is correct. Of course, there is always difficulty in calculating probabilities.

4689. *Professor Jewkes*: There is one minor point which Sir Harold can help us on. When giving figures in his own paper in paragraph 13 he talks about 100 people in the para-clinical and pre-clinical departments of the Medical Research Council and in the footnote he refers to a further 300—a total of 400, some of whom would not have medical qualifications.—Certainly, yes. I noticed that discrepancy when I looked through this and I do not know where their figures were obtained from.

4690. They are quoting 400 which would be those people only with medical qualifications.—I do not quite understand how this has arisen. I am talking

purely about non-clinical. I do not know whether it will mean all the clinical ones are included in that. I do not know how that arises. This figure of 100 I can answer for and I do not think you will find the other one incorrect.

Chairman: Thank you very much, Sir Harold. You have given us a most interesting meeting, and most useful information, and you have concentrated attention very much on part of a problem of which we are very conscious. We are very grateful to you for coming.

(The witness withdrew.)

**COMMITTEE OF VICE-CHANCELLORS AND PRINCIPALS OF THE
UNIVERSITIES OF THE UNITED KINGDOM****General evidence submitted to the Royal Commission on Doctors' and Dentists'
Remuneration****Introductory**

Many of the heads under which information is sought by the Commission are not directly applicable to members of the academic staffs of Universities. There are, for example, no established courses or schemes of training for those seeking to become university teachers and thus no useful information can be provided under the several heads which relate to "the quality and quantity of recruits", "wastage during training", "the duration of training" and "earnings whilst training". The Committee has, however, provided information under such of the remaining heads as it judges to be relevant and this is set out below, numbered according to the list of points supplied by the Commission.

2. *The quality and quantity of newly qualified members of the profession*

The number of persons starting on their careers as members of the academic staffs of Universities necessarily varies from time to time according to the actual requirements and there are inevitable difficulties in these circumstances about giving reliable quantitative information. The tendencies since the last war have been generally for increased numbers to be required but there has been substantial variation from year to year. For example, in the period immediately following the last war the expansion of the academic staffs of Universities was considerable; during the last few years the numbers entering the profession for the first time have shown a reduction; but in the 1960s there is every expectation that the numbers required will again increase. In relation to the total number of those graduating, however, the proportion required by Universities to replenish or augment their academic staffs is not significant, and in most fields of academic activity the Universities have been able to maintain, so far as their finances have allowed, a staff which was adequate numerically. The difficulties of Universities as regards the size of their academic staffs are more related to their financial resources than to the availability of candidates.

As regards quality, it is a well established principle that appointments to the academic staffs of Universities should be reserved for those with high academic qualifications and the Universities expect to continue, as they have done in the past, to recruit from amongst those who achieve the highest academic honours. Departures from this criterion are occasional and not significant in principle and are due to special factors relating to particular posts. In many fields of academic work the Universities are able to select with a fair amount of freedom from this extremely restricted class of graduates; as regards other fields of interest there is a greater competition for the services of those with the highest academic qualifications.

6. *The qualifications necessary for entry into the profession*

The minimum qualification for entry into the profession is a high honours degree of a University of standing and to this in the great majority of cases must be added successful postgraduate work for which a higher degree is frequently conferred. In addition to formal qualifications, appropriate experience is almost always essential, but within the university system there is a fair provision of opportunity for gaining such experience in the form of demonstratorships, junior fellowships, research assistantships, research associateships, etc. Other qualifications and experience are necessary in some faculties; for example in technology and in some subjects closely related to professions, professional experience and sometimes professional qualifications are necessary. Broadly speaking the practice of Universities throughout the Commonwealth is common and the qualifications relevant to membership of academic staffs of Universities in the United Kingdom are recognised throughout the world.

7. The earnings, prospects and problems of a newly qualified member of the profession

The experience of a man or woman who finds a place on the academic staff of a University is not analogous to that of a man or woman obtaining a professional qualification and beginning to practise the profession to which that qualification relates. The evolution of the undergraduate into membership of the academic staff of a University is a process involving advanced study and research coupled with the gradual acquisition of university experience. The scales of salaries current in Universities provide for employment in four main grades, namely, the professoriate; Grade I, which includes assistant professorships, readerships and senior lecturerships; Grade II, which is the great staple of the profession, comprising the lecturers; and Grade III, which includes assistant lecturerships, tutorships, etc. There are many who establish themselves on the academic staffs of Universities through the assistant lecturer grade, while others who seek academic careers at a later age on the basis of more extended experience enter the lecturer grade. The remuneration of the various levels of university employment in the United Kingdom conforms in general to a common pattern and full information is given in reply to a later question. When entry to an academic career is through employment in Grade III the salaries appropriate to the grade apply and they are related to a minimum age of about 25 or 26. The period of time spent in this grade varies but is of the order of three or four years. While an appointment in Grade III offers a high probability of a subsequent appointment in Grade II there is no guarantee that such an appointment will follow and commonly there is a maximum period for employment in Grade III. Thus a man or woman obtaining an appointment in Grade III, if a lecturership is not obtained within a period of, say, 5 years, must look outside the Universities for a career. The general circumstances of those looking for employment on the academic staffs of Universities are financially less rewarding than many kinds of employment which at that stage could be obtained on the same qualifications. To an appreciable extent therefore the Universities rely upon a sense of vocation and a liking for university life to attract men and women of higher qualifications in sufficient numbers.

9. The nature and range of expenses

The principal expenses incurred by members of academic staffs in the performance of their duties are those in respect of books and subscriptions to the journals of the various learned societies and, depending upon their particular subject, possibly also in respect of scientific instruments and items of personal equipment. It is not possible to give any indication of the range of such expenses. The extent to which they are "allowable" for the purposes of income tax varies from one district to another according to the arrangements made locally with the income tax authorities; there is no agreed schedule of expenses which are "allowable" to university teachers.

10. Existing arrangements for the determination of professional remuneration

The rates and scales of salary on the basis of which Parliament is asked to make funds available to the Universities through the University Grants Committee are determined by the Chancellor of the Exchequer. Having regard to these limits, each University determines individually the precise rates and scales to be applied to the members of its academic staff. Before reaching conclusions in this respect, however, it is customary for the heads of the individual Universities to consult together informally through the medium of the Committee of Vice-Chancellors and Principals. Representations as to changes in the basic salary framework for academic staffs may be made to the University Grants Committee at any time by the Association of University Teachers or by the Committee of Vice-Chancellors and Principals, both of which have a formal right of approach to the University Grants Committee on this subject. It is the duty of the University Grants Committee, after examining any such representations, to give a considered reply, if necessary after making a submission to the Chancellor of the Exchequer. There are no arrangements for the automatic adjustment of salaries to take account of rises in the cost of living.

13. The salaries now in force

On 12th March, 1957, the Chancellor of the Exchequer announced in the House of Commons that he proposed to ask Parliament to provide the additional funds

required to enable the Universities to bring into effect new rates and scales of salaries for full-time staff from 1st August, 1957. The details are given below.

Non-Medical Posts*

Professors: The grants will be related to basic salaries of £2,300 a year in Universities and University Colleges. Provision will continue to be made for supplementation and this will allow for a range of salaries up to £3,000 a year.

Readers and Senior Lecturers: A range of salaries with varying maxima up to £2,150 a year, or in special circumstances to £2,250 a year.

Lecturers: Scales rising generally from £900 × £50 to £1,350 × £75 to £1,650 a year.

Assistant Lecturers: Salaries rising from £700 × £50 to £850 a year.

Pre-Clinical Posts*

Professors: Salaries ranging from £2,300 to £3,000 a year.

Readers: Salaries within the range of maxima indicated below for Lecturers.

Lecturers: Scales of salary rising from £900 × £100 to maxima ranging from £1,650 to £2,250 a year.

Clinical Posts

Professors: Salaries ranging from £2,500 to £3,000† a year.

Readers: Salaries within the range of maxima indicated below for Lecturers.

Lecturers: Scales of salary rising from £900 × £100 to maxima ranging from £1,750 to £2,550 a year (or in the case of lecturers holding posts of special responsibility such as the headship of an independent department, £2,900 a year).

14. Alterations of remuneration since the war

Apart from the revision with effect from 1st August, 1957, academic salaries have been revised twice since the war. The first revision took effect from October, 1949 (April, 1949 in the case of clinical staffs) and the second from October, 1954. Details of the rates and scales in respect of each of these revisions are given below.

1949 REVISION

Non-Medical Posts

Professors: The grants will be related to basic salaries of £1,600 a year in Universities and University Colleges (in London £1,650), with increased provision for supplementation allowing for a wider range of salaries than hitherto.

Readers and Senior Lecturers: A range of salaries with varying maxima up to £1,600 a year.

Lecturers: Scales rising generally from £500 to £1,100 a year.

Assistant Lecturers: Salaries ranging from £400 to £500.

Pre-Clinical Posts

Professors: Salaries ranging from £2,000 to £2,500 a year.

Readers: Salaries within the range of the maxima indicated overleaf for Lecturers.

* Additional allowances of £100 for Professors, £80 for Readers and Senior Lecturers and £60 for others will be paid to pre-clinical and non-medical staffs of London University.

† May be increased to £3,100 in certain cases. [This figure has since been changed to £3,250 in consequence of the 5 per cent. interim salary increase awarded to consultants in the National Health Service. The "certain cases" referred to are clinical professors who do not hold either an A or a B distinction award.]

Lecturers: Scales of salary rising from £600 a year to maxima ranging from £1,200 to £1,800 a year.

Clinical Posts

Professors: Salaries ranging from £2,250 to £2,750 a year.

Readers: Salaries within the range of the maxima indicated below for Lecturers.

Lecturers: Scales of salary rising from £600 a year to maxima ranging from £1,500 to £2,000 a year (or in the case of lecturers holding posts of special responsibility such as the headship of independent departments, £2,500 a year).

1954 REVISION

Non-Medical Posts*

Professors: The grants will be related to basic salaries of £1,900 a year in Universities and University Colleges. Provision will continue to be made as at present for supplementation and this will allow for a range of salaries up to £2,850 a year.

Readers and Senior Lecturers: A range of salaries with varying maxima up to £1,850 a year.

Lecturers: Scales rising generally from £650 to £1,350 a year.

Assistant Lecturers: Salaries ranging from £550 to £650 a year.

Pre-Clinical Posts

Professors: Salaries ranging from £2,250 to £2,850 a year.

Readers: Salaries within the range of maxima indicated below for Lecturers.

Lecturers: Scales of salary rising from £700 a year to maxima ranging from £1,450 to £2,050 a year.

Clinical Posts

Professors: Salaries ranging from £2,500 to £2,850† a year.

Readers: Salaries within the range of maxima indicated below for Lecturers.

Lecturers: Scales of salary rising from £700 a year to maxima ranging from £1,750 to £2,400 a year (or in the case of lecturers holding posts of special responsibility such as the headship of an independent department, £2,750 a year).

16. *The extent to which members are required to work away from home or to move house in pursuit of work*

Members of academic staff usually choose and are sometimes required to reside in the immediate vicinity of their University and will not normally be required to work away from home. Among the Universities generally, however, considerable importance is attached to the existence of a high degree of mobility of members of academic staffs between institutions, and promotion is very often obtained by securing a more senior post at another University. This factor is of importance at all stages of an academic career and no distinction can be drawn between the early and the middle period.

17. *Any other special factors of attraction, expense or hardship, which distinguish the profession from some others*

Reference has already been made above to the need for Universities to rely on a sense of vocation and the attractiveness to some men and women of higher

* An additional allowance of £50, within a maximum of £2,850, will continue to be paid to non-medical staffs of London University.

† May be increased to £3,100 in certain cases.

intellectual ability of university life and conditions. The relative appeal of life and work in the Universities has, however, appreciably changed in the last few decades with the increasing attractiveness of employment in the government scientific service and of many other kinds of employment, both technical and general, in industry and commerce.

18. The practicability and prevalence of members transferring to other work

Many members of academic staffs, particularly those in the fields of engineering and the other applied sciences, can readily transfer to work in their own field outside the Universities. It is not possible to give a measure of the prevalence of such transfers but the Universities are constantly subject to pressure in this respect as a result of the needs of special government services, of industry and of commerce and also owing to the existence of strong competition from overseas, particularly from the U.S.A.

19. Arrangements for retiral and superannuation

The effective age of retirement in the Universities varies from 65 to 70. The normal method of provision for retirement benefits for members of staff is through the Federated Superannuation System for Universities, of which all the United Kingdom Universities are constituent members. The conditions of the F.S.S.U. require annual contributions equal to 15 per cent. of a member of staff's salary (10 per cent. being paid by the University and 5 per cent. by the member) and these contributions are used to pay the premium on an endowment or deferred annuity policy on the life of the member of staff concerned. Further policies are taken out in respect of any subsequent increments in salary. Upon retirement a member of staff receives, normally in the form of an annuity, the proceeds of the various policies held by his University on his behalf.

20. Any other relevant information

Reference has already been made to the fact that there are members of most professions to be found on the staffs of Universities. This is the case so far as doctors and dentists are concerned. In 1949 the presence of medically qualified members of academic staffs was a complicating factor in the settlement of academic salaries then reached and it resulted in the establishment of differentiation as regards remuneration between those with medical qualifications and those who were not so qualified. The further differentiation was introduced between those who being medically qualified were engaged in clinical work and those whose work though medical was not in the full sense clinical. In addition to these differentiations which will be seen to be inherent in the statements of salaries for 1949, 1954 and 1957 it is the case that members of the staffs of Universities who being medically qualified are also engaged in clinical work, are eligible together with their professional colleagues employed in the health service for distinction awards.

The terms of the statement of academic salaries reached in 1949 and 1954 and again in 1957, so far as they related to members of academic staffs with medical qualifications, were fixed having regard to the remuneration available to their professional colleagues employed in the health service. It will be seen for example that the range of clinical salaries provided for in the salaries settlement reached for 1957 makes possible the employment of medically and dentally qualified members of academic staffs on financial terms which are comparable with those which would be available to them if they were employed in the health service.

It is clear that the comparability of remuneration for medically and dentally qualified members of staffs in Universities with those which would be available to them if they were employed in the health service will no longer obtain if there is some general improvement in the remuneration of doctors and dentists employed in the health service. Further, any arrangements as regards distinction awards could not be without implications so far as the remuneration of academic staffs of Universities was concerned.

Examination of Witnesses

SIR PHILIP MORRIS, *Chairman*

DR. R. S. AITKEN

MR. J. S. FULTON

DR. T. M. KNOX

DR. D. W. LOGAN

SIR FOLLIOTT SANDFORD

on behalf of the Committee of Vice-Chancellors and Principals of the Universities of the United Kingdom

Called and Examined

4691. *Chairman*: Sir Philip, you are acting as the principal spokesman, are you, for the Vice-Chancellors?—*Sir Philip Morris*: I am acting as the leader of this group, yes.

4692. I imagine they will all say what they want to say in reply to any questions, will they?—I hope you will allow anyone else to intervene if they wish to do so.

4693. That is what usually happens, and you in your turn will be asked questions, primarily by Sir David, whom we reckon knows a bit about Universities, but also by any other member of the Commission.

When we met you once before we had a private talk, about a year ago, but on this occasion, as you know, it is in public and, therefore, anything you say ought to be something that can be written down and also something that can be heard by people either listening or taking notes behind you—the Press.—I take it, it may be used in evidence against me, even if it is, as evidence, no use to you!

4694. I propose to start straight off by turning you over to Sir David but could you just tell me first for the record what is the status and composition, as it were, of the Committee?—It is set out fully in great particularity in Whitaker and also in the Universities' Yearbook, that it is in essence an advisory committee and it exists with the authority of the Universities. It is composed of the executive heads of the Universities and University Colleges together with the addition of the Registrar of Oxford, the Registrar of Cambridge and the Principal of the University of London.

4695. In its relationship with the University Grants Committee, for instance, is there a division of functions that is easily described?—Its relationship with the University Grants Committee depends entirely upon custom and customarily the University Grants Committee regards the Vice-Chancellors' Committee as a convenient channel of consultation on matters which are of general importance to Universities. All such consultations are carried out on both sides, it being present in their minds that the Universities are each of them independent and sovereign bodies.

4696. And the Vice-Chancellors and Principals are, among other things, concerned with remuneration of all their staff and they co-ordinate their activities within the different Universities to some extent, do they?—The actual position of Vice-Chancellors in their own Universities is determined by charters and statutes of the several Universities but, I suppose, each of them has, according to the constitution of his University, some substantial part in the determination of most matters which are determined by the University as a whole. On the position of the Vice-Chancellors' Committee in relation to the University Grants Committee on salaries in general as opposed to the particular remuneration of individual people I take it there may be questions about that later and there is no need for me to explain that in advance.

Chairman: Yes.

4697. *Sir David Hughes Parry*: I think we had better start with the Willink Report, if we may. I take it you have studied it and the Vice-Chancellors' Committee have probably some views to

express on the matter. Would you like to make any comments on the Willink Report as far as we are concerned?—I do not think we have anything very important to contribute on that. You are right, of course, in thinking that the Willink Report has been considered, I expect, in all Universities that have medical schools, and it has also been considered to some extent by the Vice-Chancellors' Committee. Except for taking note of the general warning of the Willink Report that there was no need in the opinion of that Committee at present to be anxious about the adequacy of the profession so far as numbers were concerned we have taken no further action upon it at present.

4698. We are naturally interested not only in the numbers that would be taken in at the Universities but also in their quality. Have you any observations to make on the quality of those who are being recruited as students into the medical faculties? Can you make any comparison between the quality, say, to-day and perhaps immediately after the war and in pre-war days?—In the first case, as regards numbers, I think it is probably true to say that it is generally accepted that there is no need at present for proportionate expansion in the size of medical schools as the Universities themselves grow, and as far as I am aware there is no disposition on the part of any medical school to expand itself in size.

On the question of quality, I suppose that the Commission has already become aware that that is entirely a matter of opinion and not a matter of fact, and on this matter, of course, opinions differ very considerably. I think that some of my colleagues, certainly the one colleague who is himself a doctor, probably should say something about this. On the other hand, there are perhaps one or two simple things which can relatively easily be said. For example, as compared with before the war the recruitment in medical schools has been influenced in a number of directions by the general development of an awards policy. That has had a number of effects, two of which are certainly of importance. The first is that medical training has become more accessible to those who before the war would have regarded the medical profession as not

being open to them on grounds of finance. On the other hand, it has had the effect, particularly in a rapidly inflationary situation, where those who were in the kind of income brackets who would have regarded medical training as within their means found that the length and the cost of the course in relation to the available net income was increasingly oppressive.

The second point which I think could be made, sticking, which I am doing, to what is fairly common ground, is that there has been as compared with before the war a very considerable decline in the number of medical students who could be regarded as dedicated to the life of being a medical student. The proportion who would be expected to qualify in the minimum time, or with only a very reasonable over-run over the time owing to accident has increased. Whether the quality of the ablest medical students—whether they be considered either as scientists or as doctors, if there is a distinction between the two—has improved or deteriorated gets us on to ground where I think there would be probably no complete agreement. Whether the fairly large number who occupy the average or better than average positions has increased, I think everybody would agree that it has, and I think everybody would agree that the tail has sensibly diminished. As regards the comparison between students offering themselves for medical courses and students offering themselves for other courses which in some respects could be regarded as similar, again there would be a good deal of difference of view.

Might I suggest that perhaps at least Dr. Aitken, who I think you know is medically qualified and is the Vice-Chancellor of Birmingham University, should have an opportunity of saying anything he wishes to say. And on this which is so evidently and obviously a matter of opinion I think that any other of my colleagues should have the opportunity of disagreeing with anything that I have said if they have good cause for doing so.

4699. We have had many opinions expressed on this matter and I think we ought to give you an opportunity of expressing yours as we realise it is a matter of opinion.—*Dr. Aitken*: I can add very little. I agree with the

impression that Sir Philip has quoted. I have heard the same impression conveyed by a number of people and it seemed to me as likely as any to be the right one, namely, that the average intellectual quality has improved since the war and the proportion of weaker people has been less. There has been no impression conveyed to me that the proportion of very good people at the top has increased and there is a suspicion that it may perhaps be a little less.

4700. *Chairman*: Dr. Knox, I thought you were shaking your head at one remark a moment ago.—*Sir David Hughes Parry*: I thought that too.—*Dr. Knox*: I think that my medical colleagues would want to draw a distinction here between intellectual quality and what one might call moral quality, meaning by "moral" the whole of a man's personality, character and so forth. And it might be said that while you get a number of applicants who could produce more and better passes in certain examinations you could not say that the moral qualities which you often want to find in those who are going to be doctors were present in all of those who became accepted for a medical curriculum. In Scotland the experience is that the number of applicants to the faculty of medicine has declined considerably in recent years.

4701. *Chairman*: Is it still larger than before the war?—In Glasgow and Edinburgh I could not say, numerically, whether the number of applications is higher than before the war but I think it possibly is. But the proportion of the applicants that even the large schools in Glasgow and Edinburgh have to reject is much lower now than it was a few years ago. In our case, in St. Andrews, we were rejecting many more two or three years ago than we are now, and I believe that in Aberdeen last October they did not even quite fill the number of places that they had available. Overall, during the last few years, there has been a decline certainly in the number of applicants for medicine. You find that of those you accept a high proportion are, in the first place, the sons or daughters of doctors and, secondly, the sons and daughters of other professional men; and these come, according to my medical colleagues, almost always with a sort of sense of vocation themselves in that they really wish to do medicine either because

it is a family tradition or because it is the profession that they want to devote their lives to. But there is a remainder amongst the applicants who are intellectually qualified but you cannot always be certain, so my colleagues tell me, that they really have the same motives and the same personal and moral qualities that you could almost rely on, let us say, 20 years ago. That may be a point which is not altogether without importance. For a doctor you cannot just judge on intellectual quality alone and in actual fact, of course, a great many of those accepted into medical schools in Scotland have not been intellectually outstanding but they have had qualities of character and perseverance, and so forth, which have carried them through the medical curriculum. It may be that in some instances you have people of higher intellectual quality but perhaps not of exactly the same moral quality as might be desired. That was simply the experience of my medical colleagues and I wanted to try to distinguish between intellectual and moral qualities.

4702. You attribute that to the general change in the educational opportunities, do you?—*Yes*.—*Sir Philip Morris*: You will see that there are varying experiences and varying opinions.

4703. Yes, I see that.—I think that is the important point, that the experience is different.—*Mr. Fulton*: I think perhaps I ought to say I have consulted in particular one of my medical colleagues who taught in Edinburgh and is now in the University of Wales. While he would exactly re-echo the opinions expressed by Sir Philip and Dr. Aitken he did want me to add, if there was an opportunity, that he thought that the burden being placed upon these young people, whose average quality in general (not drawing the distinction made by the Principal of St. Andrews) he thinks their general average quality has not in his experience declined—he does think the burden placed on them, both intellectually and as people, has not been reduced but in fact stepped up, and that they are standing up to it extremely well.

Chairman: Thank you.

4704. *Chairman*: You may know, Sir Philip, that we are having a talk later this evening with some of the Deans of

the medical schools in which this sort of subject will certainly be discussed.—*Sir Philip Morris*: If I may be less serious for a moment—there is no harm I think in that, is there?

4705. None.—I am always reminded in trying to judge what a medical student is going to be like as a doctor by what the lady who saw medical students misbehaving in the street said to her friend, which is: "What very nasty people medical students are. How very different from the nice young doctors one meets"! One of the rewarding things in my life is to see medical students gradually emerge into full qualification and become doctors; and it would not be uncharitable to say that in many cases they have become unrecognisable in the process!

Chairman: Caterpillars are not always like butterflies, are they!

4706. *Sir David Hughes Parry*: I wonder if we could move to the second paragraph in your memorandum, the quality and quantity of newly qualified members of the academic profession generally; you indicate that in the 1960s there is every expectation that the numbers required will again increase. You anticipate that there will be keen competition still for entry on the staffs of the Universities. That is what you think, is it?—Paragraph 2 of the evidence, I think I ought to make quite clear, relates to the academic staffs of Universities generally and is not related specifically to the medical staff.

4707. It does apply to the medical staff as well as to the general staff of the University, does it?—I think that ought to be explained. The expectation, as I think members of the Commission know, is that Universities will expand very substantially in numbers between 1960 and 1970 but the expectation also is that the expansion will be unequal in various directions and that there will not be a proportional expansion, nor necessarily even, any expansion at all, in the size of medical schools. This calls attention to the fact that with increased numbers of under-graduate students as a whole one would naturally expect there to be an increase in the size of the academic staff of the Universities, if not precisely proportional, at least related. This is calling

general attention to the fact that though the Universities' demand on the available human resources of the country was big after the war it is now slightly less but in future is likely to become greater again; but the demand for medically qualified staff will certainly not be proportionate to the total number.

4708. I think I have that particular point. The next matter I would like to draw attention to is in paragraph 7, the earnings and prospects and problems of a newly qualified member of the profession. You use an expression in the last sentence which has already been used by the Principal of St. Andrews—"To an appreciable extent therefore the Universities rely upon a sense of vocation . . ."—and a number of persons who have been giving evidence to us have been using the expression "a sense of vocation". I would like you to explain to us in what sense you are actually using it here? This "sense of vocation" we have had from different persons in different contexts and we thought we understood it but I am not quite certain whether we do now.—If I was expressing this again I think I could more precisely express it as being that a man must know that it is university work that he wants to do and that he must feel that he is going to be much happier in university circumstances doing university work than he would be by using the same qualifications elsewhere.

4709. And remuneration does not enter unduly into that consideration—is that your view?—That is not the intention of this at all, no. It is intended to say that for various reasons, which I daresay you will ask questions about presently, it is not to be expected that the rates of remuneration offered by Universities will in relation to all professions be obviously competitive. Thus where remuneration in any particular case is not competitive with remuneration to be gained by using the same qualification in another sphere it is these factors which in fact enable the Universities, notwithstanding this disparity which, of course, has got to be within reasonable limits, to command the necessary number of people with the highest qualifications. Is that an explanation which makes what was originally said more clear or less clear?

4710. On your paragraph 9—the nature and range of expenses; I wonder if you

have any idea as to the range of the expenses that are allowed at the present time? Much has been said in the evidence before us about the differences in allowances by way of expenses.—We had some discussion amongst ourselves before we came to meet you and during that discussion a possible ambiguity in your original question, I must confess, occurred to me for the first time. I would prefer on the whole to divide this sharply into two questions; that is, what expenses incurred by members of the academic staff of Universities are refunded to them, which is one interpretation of expense, and the other, what, if any, allowances are made by the Inland Revenue as allowances off gross income on account of expenses?

Now as regards the first they are almost entirely confined to refunding expenses actually incurred in attending conferences or travelling on university business in one way or another. They are modest in nature, they are rigorously dispensed, and the amount of expenditure incurred in this way by Universities is severely controlled. I think that so far as remuneration, or anything affecting remuneration is concerned, it can be entirely ignored. It amounts only to doing what anybody would expect to do if he asked someone to go up to St. Martin's Lane—he would give him his bus fare.

The second is not so easy to deal with because certainly I, and I think I speak here for all my colleagues, am in no position to say what particular arrangements there may be or may have been in any particular Income Tax district on this question of expenses. My own experience is that there is no general scale of expenses of any kind or character relating to university staffs, and my own experience has been that any allowance for expenses on gross income is minimal, is accidental in fact, and that it does not reach large proportions in any case. Of course, this is a matter which is in each district entirely between the individual and Her Majesty's Inspector of Taxes and there are no general rules which can be safely applied. I am afraid that except for saying that, in relation to the academic staffs of Universities, I would not regard this as an extremely significant point from this particular point of view, it would be quite impos-

sible to give you any actual or detailed information.

4711. You see the relevance of our problem, do you not, because some of the persons who are working full time in the National Health Service are practically in the same position as the members of the university staffs?—I am trying to suggest, making due allowances for the fact that I am in no position to substantiate the suggestion by evidence, that in relation to the academic staffs of Universities an expense account is not a significant factor.

4712. No, I appreciate that. I do not think we want to pursue that further.

Can we move to paragraph 13? You deal there with the salaries that are now in force in the Universities and you divide them into three categories, the non-medical posts; pre-clinical posts and the clinical posts. The first thing that we would like to know would be an estimate of the number of persons in each category, the number of Professors, Readers and Senior Lecturers, Lecturers and Assistant Lecturers. We are very anxious to see the structure of the university staff in relation to the structure of, say, the consultant service, or anybody that we have particularly to consider. Have you any idea as to the numbers in each of the grades?—We each of us have ideas in relation to our own Universities but we have no collective information about all Universities. I thought that this question might possibly arise and, therefore, I asked the Chairman of the University Grants Committee whether from records in his possession it would be possible for him to supply you with some factual information divided into grades as between medical and non-medical staff and he told me that I was at liberty to say that he would do his best to meet your reasonable requests as regards factual information on this particular topic. For general purposes, it is of course necessarily the case, and it is an obvious truism, that those engaged in the University in teaching medical students represent in total a reasonably small minority of the total staff of the University.

4713. *Chairman:* And a diminishing one, as you said earlier.—Well, it will be a diminishing one. As regards the structure of the medical staffs, that is a

matter upon which it is very difficult indeed for us to give you any information about Universities as a whole. Even in this case the problem divides itself fairly sharply into the pre-clinical and clinical sections of the staff and I could, I think, go so far as to say that so far as clinical posts are concerned the consultant grade is in all respects of very great importance.

4714. Numerically?—Numerically in relation to the total clinical staff.

4715. *Sir David Hughes Parry*: I notice that the pre-clinical structure of Professors, Readers and Lecturers resembles the clinical rather than the non-medical structure; is there any special significance in that?—I think, generally speaking, it has to be remembered that many members of University staffs in pre-clinical posts are medically qualified. Indeed, I should think it is still the case that the majority of the members of staffs in pre-clinical posts are medically qualified and this apparent similarity reflects a natural tendency on the part of members of the same profession to expect, if not the same, at least related or comparable remuneration.

4716. *Chairman*: I think we have a figure from other sources of 176 professors with honorary contracts and eligible for awards. Would that represent the total number of clinical professors?—I should think that might be the case. I would not like to say definitely.

4717. It gives an indication of the approximate size.—It sounds a not unlikely figure to me. I think perhaps I ought to add they are probably not all professors because a member of the clinical staff of a University does not have to be a professor in order to have an honorary contract as a consultant.

4718. We have a figure of 298 other grades who are university staff with honorary contracts eligible for awards and we have this figure of 176 professors?—Eligible for awards?

4719. Yes.—Who added together would represent the clinical staff of the Universities who are of consultant rank.

Chairman: That is a total of some 470.

4720. *Sir David Hughes Parry*: These are normal salary ranges; I take it that

they apply to women in the same way as men and there is no distinction at all?—I should think that is true, yes.

4721. That is the impression one has in the Universities, that there is no distinction as regards remuneration.—Yes.

4722. It has been represented to us on behalf of the junior hospital grades that it is not quite fair, and that it was not so before 1948, to make charges for residence or to deduct lodging allowances. What is the practice in the Universities where posts are residential as regards remuneration? Are there deductions from salaries, or variations of salary ranges?—I find that very difficult to answer. I should think the practice varies a good deal. I know of cases where the salary is a gross salary and payment is made for residence. I also know of cases where the salary, together with the value of residence, represents the gross remuneration.

4723. Have you any other experience of that in the residential colleges? What happens at Oxford and Cambridge, could you say?—I would find it very difficult to reply to this very complex question on behalf of either Oxford or Cambridge, singly or together.

4724. *Chairman*: *Sir Folliott*?—*Sir Folliott Sandford*: I certainly could not say without notice.

4725. Can you say, *Sir Philip*, what the Inland Revenue do in assessing the value of residence in colleges? Do they take something into account?—*Sir Philip Morris*: I cannot answer this in general. I can answer it in regard to one or two cases which I personally know of. In one case they do take it into account; in two cases they do not and it is quite clear that the decision is made on the facts of the situation, that is, upon the reasons for residence, the nature of the contract between employer and employee by which residence is added to remuneration, and so on. I am not an expert on income tax but I would have thought that was likely to be the position anywhere.

4726. *Sir David Hughes Parry*: What we thought was that there might be a recognised practice in the Universities as regards deductions on allowances of this kind when a person was living in

—If there is, I am not aware of it. I do not know if any of my colleagues are aware of it.—*Dr. Logan*: We have very few residential posts in London but where they exist the general rule is that the salary for superannuation purposes is one thing and the actual remuneration paid is another. In other words, it usually happens only in the case of Wardens of halls of residence, but if the gross salary for superannuation purposes was £1,650, or something of that kind, the actual net remuneration with a deduction of something like £300 or so for residence would be about £1,350. I understand that in such cases that difference is not subject to income tax because the Wardens are required for the better execution of their duties to live in the halls.

4727. Have you any experience on this matter as regards teaching posts? —We have no residential teaching posts except at the women's colleges and there I think that the practice which I have described for Wardens of halls in residence applies.

4728. *Professor Jewkes*: What is the meaning of the phrase under the sub-heading of "Professors" in paragraph 13? It says there:—

"The grants will be related to basic salaries of £2,300 a year in Universities and University Colleges."

How is that related? Does it mean that the total sums made available to the University for paying Professors will equal £2,300 multiplied by the number of Professors, or if not, what is the meaning of it?—*Sir Philip Morris*: You are referring to the non-medical posts, are you?

4729. Yes.—The actual position is that the £2,300 would be regarded as the staple professorial minimum. The second sentence says that the University Grants Committee—since 1947, I think I am right in saying—had an arrangement by which there is a limited amount of money fixed as a measure of the extent to which supplementation in the case of particular Chairs can be added at the discretion of the University. The remuneration is related in the first place to the professorial minimum of £2,300 and the full range, between £2,300 and £3,000 is available for use by the University within a global financial limit.

4730. So that the £2,300 is the minimum and the £3,000 is the maximum normally?—The £3,000 is the maximum if the University can afford to pay it.

4731. How is the scale decided in these cases? Will provision continue to be made for supplementation? How is the total sum to be provided in that way decided and how is it distributed between the different Universities?—The total sum is in relation to each University.

4732. *Chairman*: It is a proportion, is it?—The total sum is determined by the University Grants Committee in relation to each University.

4733. Some will, therefore, take a bigger proportion of their salary in the form of supplementation than others, or do they all get a similar amount?—I think I might say here that I am not sure that a member of your Commission could not give you better information about the way in which this particular pack of cards was turned out in the first place than I can! There was a big variation between Universities at the inception of this scheme in 1947 in what has since become known as permitted spread. However, more recently, the University Grants Committee has rectified the situation and the amount available for the permitted spread now is determined in relation to an average salary for the professoriate in each University taken as a whole. The sum is now arrived at by a decision on the part of the University Grants Committee as to what in relation to each University appears to be necessary and then by expressing it in terms of an average salary for the professoriate. For example, if the average salary was £2,600 and there were 30 Professors the limit of professorial spread would be £9,000—30 times £300.—*Dr. Logan*: Could I just make one point? This is not a sum of money which is specifically voted for the purpose or allocated by the University Grants Committee to each University. It is a permission to each University to use this general fund for paying more than £2,300 to non-medical professors, a permission to spend out of a block grant.

4734. What I am trying to get at really is are there any statistics showing for non-medical Professors, what proportion

get £2,300, £2,400, £2,500—right up to the £3,000?—*Sir Philip Morris*: There is no published information on this whatever. The only office which might have the relevant information on this subject would be the office of the University Grants Committee.

4735. *Chairman*: Have you any idea at all, without being too specific, whether for instance in the non-medical posts the usual salary of Professors is rather nearer the £2,300 mark than the £3,000 mark, whereas at the other extreme with the clinical posts, for a variety of reasons, the usual salary is a good deal nearer the top limit?—I should think that is certainly the case.

4736. *Sir David Hughes Parry*: And for the pre-clinical posts it would be somewhere intermediate, about the middle between the two?—That would be correct.

4737. *Chairman*: Yes, so that on the whole there is really more of a difference between the clinical, pre-clinical and non-medical than appears from just the pure scales?—Are you now speaking of Professors?

4738. Yes.—Because for Professors there are no scales.

4739. I am sorry—I should say that appears simply from the fact that salaries in two cases can range from £2,300 and in the other from £2,500 to £3,000.—I think at present it is universally the case that non-medical posts tend towards £2,300 and that the clinical posts tend to be at the £3,000 point.

Chairman: Thank you very much; that is what we thought.

4740. *Sir David Hughes Parry*: Are there any figures or any estimates of the manner in which the Universities have used the amount by way of supplementation of Professors' remuneration—on what principles they have been doing it?—I think that is a very difficult question to answer.

4741. You see its relevance to us; it is a difficult matter with us too.—I would be willing to make a few comments, with which my colleagues may disagree, if they wish; and I shall now intend to speak about non-medical Professors. It seems to me that the

existence of this permitted sum recognises and accepts the necessity for taking account, in determining professorial remuneration, of events and pressures of the outside world. I think that generally speaking the existence of this permitted sum is occasioned by the unavoidable necessity of departing from what is otherwise regarded as a good academic principle of equal remuneration. It is regarded as being an opportunity to enable Universities to be more able to make good appointments in what could be regarded as highly competitive activities. I think I ought to make it clear that the discretion which is allowed to Universities is intended to be exercised by them, and thus they are perfectly entitled to exercise it in a different manner. I think I ought to explain that there is a very strong feeling in the university world as a whole that a big differentiation between one member of the academic staff and another, solely on the ground of subject, is academically to be discouraged because membership of the staff of the University is regarded in the University as involving the acceptance of responsibilities which go with the vast knowledge and training required in the education of the rising generation. And the view of the Universities generally is that those obligations do not sensibly change as between one subject and another, at least as far as the most important things related to them are concerned. At the same time Universities have been obliged—not without great reluctance—to accept the necessity for some differentiation; but they have been at very great pains to press for the retention of a discretion—within, of course, permitted limits—to exercise in a way which they regard as being most suitable to their own particular needs and requirements. That may sound a little more complicated than necessary, but in fact it is not, because I think it has to be remembered that Universities are very differently composed. They represent a different spread of subjects. For example, many Universities have no medical schools at all, so they are not affected by clinical and pre-clinical distinctions. The same would apply to technological fields, which in many cases are not represented at all and in other cases are represented to a very large extent; so the problem differs as a matter of fact. This is not

just a position of unnecessary complication arising from an academic point of view: it arises from the facts. The second point which has to be borne in mind is, as Dr. Logan reminded you, that this permitted spread, although expressed in terms of money, does not represent cash. The cost of any supplementation which is added to the basic professorial salary is a charge on general income and competes with everything else which seeks to become chargeable to general income. So the University is under very considerable limitations in exercising this discretion, and Universities have never suggested—nor would they, I think, ever be likely to suggest—that they should have anything but a limited discretion. They might argue about what the limits should be, but they would not argue against the need for a limited discretion.

4742. *Sir David Hughes Parry*: No conditions were laid down by the University Grants Committee as to the manner of the exercise of the discretion?—No.

4743. *Chairman*: Are most Professors—I am dealing entirely with the non-medical side, as I think you were, Sir Philip—employed whole-time by the University, or have most of them other sources of earned income as well?—I should say that the vast majority of them are full-time.

4744. And those that do earn outside, for instance, if it happened to be a Professor of architecture doing some architectural work for a client, or a Professor of economics broadcasting and writing articles, and so forth—is that normally brought into account in any way, for instance, in deciding the permitted spread of the University. Would any account be taken of the fact that some types of Professor are more likely to be able to earn outside than other types?—There is a danger of giving you a very frivolous answer to this, but I will not! This question of additional remuneration is a very difficult one to deal with justly. A Professor of Nordic, whose excellent qualifications are not deployable in the world except in a University, can easily write a best seller and can, by this means, attract infinitely more money than even a consulting surgeon could earn, even if he were allowed to spend his spare time operat-

ing for gain. However, I should have thought in the first case that no Professor of Nordic would regard himself as being under an obligation to take the income and royalties from his best seller into account in determining remuneration. I should think such a Professor would be somewhere down towards the professorial minimum than rising anywhere near the actual average clinical remuneration. I have given that example deliberately because that represents one limit in the structure. At the other limit there are, as you must well know, some Professors in Universities whose services are very highly sought after for a very large number of purposes, and one of the big contestants for the services of those whose ability is the highest is the Government itself. It is certainly true that the Government is never a generous paymaster in this respect, and in my own experience the Government has never yet offered enough to create embarrassment so far as my own University is concerned. In other consultant appointments I think the general situation could be explained in this manner—I think most Universities have a kind of system by which contracts of this character entered into by the professorial staff are, by one means or another, declared and made known to the office of the Vice-Chancellor or to the University, and the additional remuneration earned in this way is kept under supervision in that manner. I can only speak from my own experience, but within my own experience the additional remuneration obtained in that manner has always been within such reasonable limits that no one could regard it as being an amount which ought to be taken into account in determining remuneration. If one got to the point where one had to look at it in that way, one might easily find that here was a position of "unto him that hath most, most shall be given", because his abilities were evaluated on the most lavish scale in the outside world, and that would be an indication of how much his services were in demand. Fortunately, that limiting predicament very infrequently arises.

4745. But on the whole, in the University you would think it is quite important to keep a pretty fair relationship between the Professors in the different types of

study?—Oh indeed we do. We should like what we call various gaps which have opened up to be kept within limits, and some sensibly closed, and if you look at the three sets of figures we have given, you will see that the opportunity was taken, on the last occasion, sensibly to diminish a number of cases.

4746. *Professor Jewkes*: That is shown in paragraph 14. May I just ask, on paragraph 13, about the permitted range? After all, it is not a very narrow one, it is £2,300 to £3,000. It is a fairly wide range. Can you give us any advice on the principles which are followed by Universities in deciding whether the figure is to be at the higher end or the lower end? For instance, why should the Professor of Nordic be placed lower—I think you mentioned he was to be at the bottom?—I think, in the first place, the actual extent to which that range can be used is affected by the permitted sum, which restricts the total amount of supplementation; and I think, in the second place, there is no actual possibility at the moment in relation to general income of the hope of this range being effectively used in the non-medical field. In the third place, I think that in many cases decisions are made on mixed criteria, and it would be an assessment on such unlike criteria as personal eminence, obvious high value of services—either to a department or of the subject to the University as a whole—and, of course, in many cases the actual nature of the subject and the work done and the responsibilities which go with it. For example, you would naturally expect a very expensive technological department, or a very expensive pure science department, with a Professor at the head of it—if the appointment had been well-made—you would naturally expect him to be well up in the professorial spread on all three grounds, eminence, responsibility and the fact that he was engaged in an activity which was very highly remunerated elsewhere.—*Dr. Knox*: Could I add one point about this? Some Universities took the view when they were told, "Here is a global sum which you can spend if you can find it out of your general grant, for lifting professorial salaries above the minimum", that what they ought to do was to try to diminish the gap between medical and non-medical

staff, and they divided it more or less equally between them. Other Universities took the view that what they ought to do was to remunerate more highly the people of personal eminence and the heads of big departments, and so forth. Both of these quite different criteria are in use in Universities, and as Sir David says, there were no rules laid down when this business began. That is the position today. There are some Universities with one system and some with the other—some wanting to close the gap between medical and non-medical, others wanting to give special salaries to certain special people.—*Dr. Logan*: There are even wide variations additional to that. In London the general view was that part of this permissible grant should be allocated among all Professors and the rest used for this purpose, and one Institution at least has used the rest to give salary increases on a pure seniority basis. There are almost as many ways of dealing with this problem as there are those who have to handle it.

4747. *Chairman*: And that is a satisfactory position, that there should be many ways and some flexibility in dealing with this according to circumstances, whether geographical or at any point of time?—I think it is a very good thing to leave the discretion with the academic institution.

4748. *Sir David Hughes Parry*: Within the limits prescribed by the University Grants Committee.—Yes, to settle the matter in relation to its own needs.

4749. *Chairman*: Could you give us just an idea as to the size of this permitted sum in relation to the total salary for Professors? This is given to the Professors, is it not?—*Sir Philip Morris*: Yes.

4750. Is it of the order of 10 per cent to 15 per cent of the sum paid out to Professors, the amount that can be spread at your discretion?—*Dr. Aitken* says 12 per cent, but I would like to do some arithmetic before I give you my answer; it is probably of the right order; it is between 5 and 15 per cent.

4751. *Sir David Hughes Parry*: It may be that we could get the actual

figure from the University Grants Committee.—Well, it is capable of being worked out theoretically.

4752. *Chairman*: Is it in fact calculated or allocated on that basis, as a percentage?—No.

4753. It is not: it is a sum which has no relation to anything in particular?—It is perhaps a more complicated calculation than one might think, but it is capable of being worked out theoretically.—*Dr. Logan*: You can get the information from the U.G.C. We are not in a position in our own University to know what is happening elsewhere. Some of us may have shrewd suspicions of what happens at other institutions, but we do not know what happens over the whole scheme. It differs from University to University.

4754. *Professor Jewkes*: One point I am particularly interested in arises out of a discussion we had this morning with a witness who was talking about the relationship between clinical and pre-clinical salaries—medical people in Universities. The moment one begins to discuss that, the question of the relationship between pre-clinical scientists and other scientists comes up. I was wondering whether you could give us any indication as to whether, in the operation of the permitted limits, the different Universities have tried to increase science salaries in relation to professorships in the arts, because it affects the relationship between the pre-clinical salaries and science salaries. Is there any attempt to widen the gap between science and the humanities?—The University Grants Committee would have the information. I am perfectly willing to give you the position in London, however, where I would say that the average salary of a science professor is about £100 more than the average salary of an arts professor—but that is only the situation in London.

4755. But in most cases the gap would be small?—*Sir Philip Morris*: Again, we only know the situation in each of our Institutions. It rather masks the information which you want if it is dealt with in terms of averages, because the average itself represents considerable variation within the class of which it is an average.

4756. And the position may differ widely from University to University?—Yes.

4757. *Chairman*: But broadly, I think you have said already that, in general terms, most of the clinical professors will be on the £3,000 or very near it; that most of the non-medical people must be much nearer to £2,300 than £3,000; and that the pre-clinical ones are somewhere in between.—I do not think anyone would disagree with that.—*Dr. Logan*: It is true, but in London, owing to the difference of the consultant grade salaries, there are increments for clinical Professors; so a Professor will normally go to the maximum. In the case of a non-medical Professor, his chances of getting £3,000 are very limited indeed.

4758. *Sir David Hughes Parry*: May I just ask one more question on paragraph 13? It has been represented to us that there ought to be extra payments for administrative duties. Are there any examples in Universities of extra payment to members of their staff for purely administrative work because it adds to the responsibility and work? It is a question of extra remuneration outside the scales.—*Sir Philip Morris*: Of extra remuneration, I expect there are cases: whether they are outside the scales is a separate issue, because they could easily be inside the scales and still receive extra remuneration for extra administrative duties.

4759. Yes, I appreciate that.—In my own case, with the exception of certain administrative duties which are not related to the departmental position of the person concerned, there are no such payments for administrative responsibility. Where they exist they are very small in character; they are honoraria and relate to a certain state of affairs. For example, I know of a case where a person receives an additional payment of £100 whilst he occupies a job, which he will only occupy for as short a time as he can, and will willingly pass on the work and the £100 to somebody else at the earliest opportunity. That is the only case of which I have direct knowledge, but I believe there are examples of administrative duties being taken into account in this manner in operating the permitted professorial spread, and that would be a case of supplementation being given over and above £2,300, on account of administrative duties.

4760. The examples are not many?
—No.

4761. *Chairman*: Would that be true at Oxford, Sir Folliott Sandford?—*Sir Folliott Sandford*: You would find a number of cases at Oxford.

4762. Would you also find people who had college responsibilities getting additional remuneration for work they did for the University?—Yes.—*Dr. Logan*: But in the wide run of the cases, it is nearly always Professors who have these administrative duties. If a non-medical Professor is paid for administrative responsibility, that must come out of the permissible grant. You cannot pay for departmental responsibilities over and above the permitted amount. It is one of the factors taken into account in most institutions in quoting the permissible salary.—*Sir Philip Morris*: In relation to Professors, it would be a different method of arriving at the utilisation of the permitted spread and not an addition to it.

4763. I am trying to establish this point, for instance, in relation to superintendents in mental hospitals in Scotland, where it is suggested that because they are at the same time medical staff and superintendents, as it were, they should earn rather more than if they were simply consultants without the administrative side as well. That is the kind of parallel in your case, so far as you can say for Professors—there is a bit of adjustment within the ceiling?—Yes.

4764. But it would count for something?—It might.

4765. Yes, but not for very much.—*Dr. Knox*: In at least one Scottish University, it would count for nothing.

4766. *Sir David Hughes Parry*: Now may we move on to paragraph 14—alteration of remuneration since the war. Are there any records of the position, say, in 1938? We have 1949, 1954 and 1957.—*Sir Philip Morris*: These are three revisions of academic remuneration which have taken place since the war, and that is why these three are given. They represent the whole of the post-war story. As far as pre-war salaries were concerned, the position of remuneration in Universities was entirely different. There were then entirely individual arrangements between Universities and their staffs. The 1949 position really

represents the first systematic settlement of ranges of salaries and salary scales for Universities as a whole. If you should wish to make comparisons between this state of affairs and the state of affairs which existed pre-war, you would necessarily have to go to the University Grants Committee for the information. There is no reason why the Committee of Vice-Chancellors would wish to have it, and there would be no ordinary manner in which that information would collect in the office of the Vice-Chancellors; but such information as there is, the University Grants Committee would certainly have.—*Dr. Logan*: There are certain statements made in the development reports of the University Grants Committee about average salaries at the date of the report, and so forth. There is a figure for 1938-39 in the U.G.C. development report for 1945-47.

4767. *Chairman*: Yes, there is just one further point on that. Again, when we were talking to the Medical Research Council this morning it emerged that before the war the salaries of clinical and non-clinical people were virtually the same, and by the end of the war there was a certain difference of about 6 per cent. Now, of course, there is a very large difference in the ceilings because of the operation of merit awards. Quite apart from merit awards, there has been a difference since the war in the non-medical, pre-clinical and clinical posts. Do you know whether that was so before the war all the way down?—*Sir Philip Morris*: I think it would be very difficult to answer, and one has to remember that in a large number of medical schools there were many fewer full-time consultants on the staffs of Universities. The pattern of organisation has changed so much that comparison between now and before the war would be to a large extent false for that reason.

4768. *Sir David Hughes Parry*: In the medical field, that is?—Yes.

4769. Now I wonder if you would explain this: when I saw the dates 1949, 1954 and 1957, I thought there was something significant as to why the reviews should take place in those years. Could you give the background to each one of them?—I should think that in all probability the 1949 review was occasioned by medical remuneration.

Certainly medical remuneration in relation to the Health Service triggered it off, if it did not actually completely cause it; but I would say it would be perfectly fair to regard there being a close linkage between medical remuneration and these reviews, so far as 1949 and 1954 were concerned.

4770. 1954 is the same, is it?—Yes; I was speaking both as regards 1949 and 1954, but the same is not the case with regard to 1957. The 1957 review was occasioned by two factors operating, I think, unequally. The first was general inflation, with the general cost of living justification, but the other was a recruitment factor. It was felt very strongly, and it was subsequently—to the satisfaction of everybody—proved sufficiently, that recruitment was suffering and was likely to suffer unless there was a substantial change in the remuneration of the academic staff at Universities, and particularly at the bottom and at the middle.

4771. *Chairman*: How long did it take from the time you started to establish that fact and the time in 1957 when the changes were agreed? Was it a matter of months?—So far as arguing and establishing what it appeared should be done was concerned, the time occupied was relatively short. I can put it at probably three to four months. As regards the hiatus before really serious discussions between the parties took place, there was a much longer period, and subsequent to the serious discussions to arrive at a pattern which was capable of being justified, the time which was taken by the Treasury finally to agree to it was somewhat protracted.

4772. *Professor Jewkes*: Do you happen to recall the date, Sir Philip, in 1956? The dates happen to be important for our purpose.—*Dr. Logan*: I can give you the general picture. At the beginning of 1956 it was felt that the situation was likely to arrive where a change in salary structure was necessary. I think the informal discussions, to which Sir Philip referred, took place between about June and October. The announcement was made by the Chancellor of the Exchequer in March, 1957, and I regret to say that the salary increases did not come into operation until the following 1st August.

4773. Did anyone tell you, as they told the doctors in the same period, that the country was in a serious economic crisis and that there was a grave danger of inflation if the salaries were raised?—*Sir Philip Morris*: It was said on both sides that there was very grave danger of inflation. As regards the first, I am not sure that the argument was used very much in my hearing, but no doubt it was an argument which was used fairly strongly as between the Treasury and the University Grants Committee. That could be the case, and as to that I think your question should be addressed elsewhere.

4774. *Professor Jewkes*: There is another point. You made the interesting comment that the 1949 increase and the 1954 increase were probably triggered off by earlier increases in the remuneration of doctors. Do you feel that the 1957 increase triggered off a demand on the part of doctors for an increase in their remuneration?

Chairman: I think the dates do not quite fit.—I should have thought the action on account of the Universities occurred after the doctors' application had already been triggered off.

4775. *Professor Jewkes*: I am trying to see how far they affected each other.—I should say they were chronologically arranged in the reverse order, so that causality could not be inferred. I would think that these were activities which were related but not directly.

4776. A current occurrence but different treatment? The Universities got their increase, but the doctors did not.—I suppose one has to see the end of this matter in order to turn it into a relative advantage or disadvantage.

4777. *Sir David Hughes Parry*: You have now taken us almost to the next matter, namely the methods of assessment of salaries. A new scheme, I understand, was introduced about two or three years ago. It determined the range of university salaries—is that right?—Yes.

4778. I wonder if you could give us a general description of it, together with any comment that you would like to make on the way it is working—if it has been working—since it was instituted.

—Yes, I think I must be allowed to begin by a short explanation of the general situation. The Universities are independent, autonomous authorities, and each University is an employer; there is no federation of employers. The Universities are governed in such a manner that they have a large measure of self-government, and those who receive remuneration from Universities are themselves concerned, to a greater or lesser extent, according to the occasion and the subject matter of the University, in the government and administration of the University which they also serve. There is therefore a very special position arising here. In the second place, there is an Association of University Teachers. That Association, while representing some members of the academic staffs of the Universities, is not itself recognised as a union, but it does feel itself, and has the right, to have views and to make representations on the subject of remuneration at large. During 1953-54, and especially during 1954, the Association of University Teachers felt itself under an obligation to press very hard for some kind of recognition in the machinery which was to be used for the purposes of reconsidering, and, if necessary, revising remuneration. After a good deal of discussion—and not without some difficulty—it was eventually decided by the Chancellor of the Exchequer in 1955 that the Association of University Teachers ought to have an opportunity either of approaching the University Grants Committee on the grounds of the inadequacy of the remuneration and/or of being consulted before the University Grants Committee made submissions to the Treasury in relation to the remuneration of the staff of Universities. Eventually the University Grants Committee, after some consultation with the A.U.T.—and with the Vice-Chancellors' Committee, I think—decided that the Association of University Teachers should have the opportunity of approach to the University Grants Committee on the question of salaries at any time; and that the University Grants Committee should feel itself under an obligation at least to give the Association of University Teachers the opportunity of expressing its views before it made representations about salaries. But that was all subject

to the continuing right of the University Grants Committee to consult with the Committee of Vice-Chancellors, the best available body to consult with them and advise them about general matters affecting the remuneration of staffs of Universities. It was hoped, at the same time, that the Vice-Chancellors' Committee would find itself able to make some arrangement with the Association of University Teachers by which those two bodies found themselves able to have, without any commitment on either side, general consultations on the subject of academic remuneration. So the present situation is that the Vice-Chancellors' Committee does continuously generally consult with the Association of University Teachers on matters affecting salaries; and also on certain other matters, but I do not want to mention those, because it would distort the picture if I did. Those informal consultations are carried out on the basis of sharing views, and of avoiding unnecessary differences, but neither side is prevented by anything which takes place in such informal consultations from making just what representations it feels it ought to make to the University Grants Committee. In practice, the bodies, both being reasonable bodies, would feel themselves under an obligation to behave with strict decorum on a matter of that character. And on this last occasion they were carried out in such a manner that I think it would be true to say that we knew pretty well where each other stood at all relevant times. The University Grants Committee is finally responsible for making representations to the Treasury and eventually, if necessary, of producing a reasoned case for the representations which are made, and subsequently for passing on the result to the A.U.T. For this purpose, the University Grants Committee sits in a different manner from the way in which it sits for all its ordinary business, but as to that you would probably wish to ask the Chairman of the University Grants Committee himself. That, broadly speaking, is the picture. Nobody, I think, who had the arrangement of matters at his disposal, would ever have invented this particular way of doing things; but you will see that it has grown out of difficult circumstances. It would, however, be true to say that it has

worked not unsuccessfully, but whether it worked not unsuccessfully would be influenced, I think, both by the prevailing circumstances and also by whether the outcome appeared to be successful on the one hand, and on the other hand it would be very much influenced by the actual persons who happen to be chiefly engaged on both sides at the relevant time. I am sorry to have explained that in such an apparently complicated manner, but it is my duty to make it abundantly clear that the arrangements are not arrangements of joint negotiation; they are not the customary arrangement of joint negotiation found outside—nor could joint negotiation be arranged without making a lot of alterations to the status and position of the Universities, and in a lot of other directions. This is the nearest approach we can get to some form of joint consultation—with a small j and small c—and it is the best way in which we can get the various bodies in a relationship to each other which is regarded by each of them as being reasonably satisfactory.

4779. *Professor Jewkes*: Still on paragraph 14, I was going to ask you, Sir Philip, about a matter which I think you started to raise yourself some time ago. If you look at paragraph 14 it is quite clear that, as between the three groups, non-medical, pre-clinical and clinical, there has been a movement towards equality of earnings. That is to say, the non-medical earnings have gone up 44 per cent, the pre-clinical by 20 per cent and the clinical by 9 per cent. Has that been deliberate policy?—I would say yes, on the whole, arising rather in this manner—that the position as regards remuneration of the academic class generally was admittedly extremely unsatisfactory in 1949. It was, I think, fairly generally concluded that, in relation to medically qualified people, there had got to be a very considerable improvement; but it was felt at the time to be very difficult to let what was a good argument in relation to medically qualified people apply directly to other members of the academic staffs at Universities. In 1954 a similar state of affairs existed, with a very slight difference. The general pressure of opinion in the Universities had begun to have an effect, and that general pressure was towards a greater degree of equal re-

muneration between people who were members of the same academic community and who had in many respects precisely similar functions to fulfil, though in relation to different subjects. In 1957, the basis of the revision was different because it was much more on the grounds of recruitment and of guaranteeing that the Universities would be able to obtain the necessary staff to make the Government's expansion policy possible. The pressure on Universities to do something to remove the big differences between medical and non-medical remuneration had even more force on the 1957 occasion than previously. It would not be untrue to say that in 1957 part of the objective was deliberately to eliminate to the maximum possible extent the basic difference between the pre-clinical and non-medical remuneration.

4780. *Chairman*: With the recruitment position as you have explained it during the next ten or fifteen years, with a great expansion in the Universities but not in the medical schools—do you envisage that it will become even more important to reduce the differentiation?—The differentiation, except in quite unimportant respects, between the pre-clinical and non-medical has been practically eliminated except for the professorial rank. The position as regards medical remuneration is that in the 1957 revision the position as regards full-time medical staff in Universities was not unsatisfactory in relation to the then level, and even to the present level, of consultant remuneration. Of course, if the consultant remuneration changed very considerably we should, to a large extent, find ourselves back in a position analogous to the 1949 position.

4781. But just below the Professor are the Readers and Senior Lecturers, Sir Philip. I am not absolutely clear, but I think the Senior Lecturers in the non-medical posts have a range of salary varying to a maxima of £2,250. In pre-clinical, it is with varying maxima up to £2,250, and in the clinical it is £2,350. It is not distributed evenly among Readers and Senior Lecturers.—No, but it is very small in relation to the clinical posts. Of course there is a very big gap still, and generally speaking, with regard to Lecturers and Senior Lecturers and Professors in the clinical range, their salaries can overlap: for example

there is no reason why a Reader who is a clinician should not be paid more than a Professor.

4782. Should not the same thing apply for Reader and Senior Lecturer as to Professor? That is to say, on the whole in the clinical posts, they are nearly at the top end of the scale—the top end of their various maxima mentioned would normally apply; whereas in the non-medical posts they would be nearer the bottom end of the maxima. If you take the Lecturers in the pre-clinical grades, you say there is a range of £1,650 to £2,250—which is quite a range. Would you say that most of the Lecturers in the pre-clinical posts are the same?—I would not say that general difference was valid at the Readership and Senior Lecturer range, as between non-medical and pre-clinical, but the Lecturers are *sui generis*.

4783. *Professor Jewkes*: You thought it was a good academic principle that there should be equity of payment between the teachers of the same grade in different faculties. Can you just enlarge on that? Why do you think it is a good principle?—I wonder if you would like to make it easier by taking out the word "good"? I argued that it was a well-established one.

4784. Yes; then why do you think it was well-established?—I think it springs in the first place from the fact that Universities developed from being small and domestic close-knit communities, in which they regarded their obligations as being more on an equality because of the human responsibilities they have—those with whom they work and those who they teach—rather than as being unequal because of the kind of subjects which they used for the purposes of teaching. I think that is where it begins. It goes further; because I think that Universities generally have wished to avoid big social disparities within communities, and they have wished to prevent that state of affairs occurring in which they have very different kinds of manners of living going on amongst people who really should be working closely together. I suppose, shortly, one of the arguments which is strengthened by the first two is if there is competition anywhere, of course it does assist you whenever you wish to argue that the general level of remuneration should be raised. I think that is

being quite fair to the argument, but I daresay that possibly my colleagues may like to differ on this, and if they do I think they should say so.

4785. *Chairman*: Yes, please.—But that is the position as I understand it, speaking as one who has comparatively recently come into the university world, and has for himself tried to find out the importance of this particular phenomenon.

4786. *Sir David Hughes Parry*: I wonder if I could take you a step further? It has been represented to us very strongly that the merit award should be extended to those who work in the scientific medical field, although they are not registered for medical purposes. Would there be any repercussions or reactions in the university world if there was an extension?—We have considered this on many occasions, not without anxiety. I think that, in accordance with the point of view which I have tried to explain, the merit awards would not be, as you would expect, very attractive as far as the Universities were concerned at all. They do represent a fairly substantial variation between some members of the staff of Universities and the rest. At the same time the merit awards, as they are at present operated, have been simply by the operation of time accepted as being both logically founded and reasonably and sensibly limited, and I think nowadays most people, including, for example, less well remunerated Vice-Chancellors, have got used to the idea of a full-time clinician getting a higher total remuneration, on the grounds that he has all the pain and anxiety and worry of actually carrying out clinical duties in dealing with actual patients. That seems to represent a clear, acceptable and "justifiable" criterion. It is the cause of some embarrassment and anxiety, but at least it is embarrassment and anxiety within reasonable limits. An extension of the merit award system beyond those who were actually put to the pain and suffering of dealing with clinical work and actual patients, would certainly increase our difficulties and embarrassment and would certainly cause problems for us. We have thought very seriously whether it was either possible for us, or indeed our duty, to try and find some other alternative proposal which would be free from some of these difficulties and in

itself defensible; but we think that we are neither responsible for making any such suggestions nor if we were, that there were any suggestions that we could make. We have been forced—not without difficulty—to the conclusion that the merit award system, as it now exists, though embarrassing, is tolerable; that its alteration or extension might be even more embarrassing and consequently intolerable, and that it would certainly have repercussions, but those repercussions would be very difficult to forecast unless we knew the nature of the changes.

4787. *Chairman*: Sir Philip, you were talking to Sir David about the extension to a fresh class of recipients; but would your answer be the same if we had been asking you what you would think of increasing the amount of a merit award or increasing the proportion of those now eligible who might obtain it?—It would not be quite the same but in some respects it would be similar. A considerable increase in the incidence of merit awards or in the amount would have such an effect on the actual remuneration that of course it would have a repercussion of some kind—how big would depend on the size of the extension and the amount of increase—on the salaries position generally. It would not be the same because the departure from the present criterion, by which merit awards are confined to those who are actually responsible for the treatment of patients and have all the disadvantages and responsibilities and the rest that goes with it, would of course introduce another factor altogether.

4788. We have heard, Sir Philip, that doctors who are not just right within the National Health Service but who are employed in other ways such as medical officers of health are anxious to be treated not as members of the particular community of civil servants or whatever it may be in which they work out as doctors, and remunerated accordingly. On the whole, in the University you favour a university community where all Professors can look to each other with an equal amount of respect and think of themselves first as Professors?—That I think would be true.

4789. That really is the position of the Universities as a whole?—Yes.

4790. And, Dr. Aitken, that would on the whole go for the clinical faculties, would it?—*Dr. Aitken*: I think, Sir, I would rather put it this way, that there are two forces operating, both of them quite strong and important. One is that we wish a university community to be a community of people and not just an aggregation of persons coming in and doing their jobs and going home—and these considerations about salary have an important bearing on whether they do become a community of people; we take them very seriously. But the other force that we have also to take very seriously is the problem of recruitment subject by subject and faculty by faculty in the light of the available numbers of good people in each line of country and the demands for them and the rewards offered to them outside. It is obvious that that forces us, and has forced us, into a differentiation of salaries between medicals and non-medicals and even, as you heard, to some differentiation of salaries within the non-medical professorial group. I hope at least that all, or very nearly all, the justifications we gave for differentiating salaries among the non-medical Professors—we had a list of them a little while ago—are ultimately referable to the problem of competition outside and the need to attract to the University a sufficient number of top level people.

4791. Might it be that some entirely different Chair, for instance of nuclear physics or engineering, because of competition from industry and outside generally, had to be dealt with in the way that clinical posts have had to be dealt with in the past, and would that be a very great trouble if it arose?—I think it is not unlikely that in the near future we may find that it is difficult to maintain in some of the engineering Chairs the level of quality relative to the engineering profession outside that now obtains between our medical professors and the medical world outside. That is to say, the problem that you adumbrate may easily face us quite soon.

4792. Would you feel that is something you could deal with more easily, without making the University less of a community, than if you had to give, for instance, an extra £1,500 a year, say, which is less than some of the top medical Professors get altogether, over other Professors? Would that upset the whole

university structure?—The point of compromise would move a little, but it would not upset the whole thing if it were sufficiently limited in extent. My initial point is that we have got to accept the resultant of two forces and we do not want to go too far from the middle path.

4793. *Professor Jewkes*: How far might you be forced away from it? Take the position of science and scientists. If it is generally accepted that there should be more scientists and science teachers in the Universities might it not be a good thing to have an increase in the remuneration of scientists without an increase in the remuneration of other Professors? Otherwise if you gave them all an increase it would frustrate the scheme, would it not?—That is something we would have to examine in the light of the situation at the time.—*Sir Philip Morris*: I am not sure that it really frustrates the scheme because at any particular time at which this is done these are not interchangeable units and cannot compete with each other for the same post.

4794. But in so far as they are interchangeable units?—Originally?

4795. Yes.—In so far as they are interchangeable units; but in a number of cases they are not interchangeable units, so it would theoretically be perfectly possible in the short run to raise the salaries of all members of the academic staff on the grounds that it was absolutely essential to raise some. It would be theoretically possible in the short run.

4796. *Chairman*: Provided you could get the money?—Yes, I mean in relation to this question of achieving the object.

4797. *Professor Jewkes*: We are always being told it would be easy to divert people from humanities to science without anyone suffering.—It takes a long time. As everyone knows, the diversion of people from one field of activity to another involves a totally different time factor from, for example, changing from employment in a University to employment in an industrial firm in the same activity. They are really not in *pari materia*, the two problems, are they?

4798. I am an economist and I suffer from the disadvantages of my profession, but surely if one thought in terms of getting the most rapid increase in the number of scientists in the Universities,

both teachers and undergraduates, it would be better to raise the remuneration of the science teachers without raising the remuneration of the people in the humanities, would it not?—The long-term effect of doing that might increase the number of people who had directed their course towards science teaching in Universities, but as between people who offered themselves for appointment in science posts and non-scientific posts it would have no immediate effect whatsoever between those two. It would give the Universities a better position possibly because the remuneration was higher in relation to other scientific employment.

4799. *Chairman*: But even taking the long-term effects, Sir Philip, is it not normally so that a dramatic change in the relativity would be more likely to have a marked effect on the one hand in attracting recruits and on the other hand in upsetting the university community, and that a comparatively small or gradual change would cause much less upset in the community of people but would not have quite the same effect in strength? It is rather difficult to get both.—Universities would have to be, I imagine, always reasonable enough to recognise the necessity on occasions for some differentials, but they would wish the general policy in the long-term to return to at least a middle course, and they would not be disposed to accept that, in order to attract from one field of activity to another field of activity, a big change of remuneration could in the nature of things be justified. They would accept that some change of remuneration might conceivably be justified by the necessity over a longer term to direct parents' and boys and girls' interests in different directions, and that might indeed operate. But if the Universities themselves, for example, were asked to operate a scheme of the scale, character, scope and weight of the merit award system as applied to clinicians it would be, I should say, beyond the limits of tolerability and would be exceedingly disruptive.

4800. Looking to both the areas over the next generation shall we say, are you on the whole wanting to influence fewer people towards medicine and more to some of the other sciences which are linked together, so far as can be seen? For instance, the new Churchill College

and such things might seem to imply that.—I think it is probably the case that medical schools will not in fact expand to any considerable extent, and the need of Universities for medically qualified staff will be related to the size of the medical schools.

4801. It might mean during the period if there were continuing alteration in the general level of salaries that the non-clinical might catch up further, and quite a bit further, within the next twenty years. But there is certainly no permanent relation, is that right, between the clinical and the other kinds of Professors?—I am not so sure of that. It is a little absolute to say there is no relationship, because there is this pre-clinical group. "Pre-clinical" is an ambiguous phrase because it includes people who are medically qualified and those who are not, but it operates as a very powerful link between two things, and the two extremes could be regarded as being entirely different—the clinicians on the one hand and the totally non-medical on the other.

4802. Again, if we think in terms of the Medical Research Council, there has been a very sharp change in the relationship between pre-clinical and clinical at the top levels since before the war.—A change?

4803. The relationship between the top salaries.—In remuneration?

4804. In remuneration.—Yes, but then there has been a change in the relationship between non-medical and medical remuneration, ignoring for the moment merit awards altogether. I would say what occurred under the Medical Research Council is analogous to what has been occurring in the Universities.

4805. *Professor Jewkes*: We have discussed what might be the reactions if you widened the circle for merit awards, but supposing we take another hypothesis: say the earnings of whole-time consultants were increased. Would you assume that inevitably meant the remuneration of medical professors would have to go up and, if so, do you think it would have other reactions in university earnings?—I think that an

increase in consultants' remuneration would have a direct impact, and I think it would certainly have indirect consequences. Further than that I could not reasonably go because I do not think one should commit oneself to an attitude on a state of affairs which has not in fact arisen. Of course we none of us know—we all have very big responsibilities in these matters—we none of us know in precisely what circumstances an event of this kind would arise, but in principle I should be obliged to say that there would be a direct impact and indirect consequences.

4806. *Sir David Hughes Parry*: Professor Jewkes has asked my question about the repercussions if there were a general alteration upwards of the remuneration of those in the National Health Service, and particularly if there were added remuneration to the consultants. You have answered it.—Yes.

4807. Is there any comment or any observation you would like to make on any other matter, or any expansion or enlargement on any matter that you have submitted by way of evidence that you would like to make? I would like you to have the opportunity to do so.—An opportunity which I very gladly pass on to all my colleagues, if there is anything they have so far been prevented from saying which they are anxious to say. For my own part I am only too willing to stop saying anything.

4808. *Chairman*: I hope someone will take up Sir Philip's challenge.—I can only conclude that we have had the opportunity one way or another of saying everything that was worth saying.

4809. *Chairman*: Thank you very much, Sir Philip, and all of you for coming. I think we have covered all the important points that we meant to, and you have been of great assistance to us, because we know the University is one of the places where the impact of any change in medical remuneration is greatest. Thank you very much indeed.—You have a right to summon us to appear; otherwise I would thank you for receiving us.

(The witnesses withdrew.)

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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

20

Twentieth Day, Thursday, 19th June 1958

WITNESSES

Scottish Association of Medical
Administrators
Medical Superintendents' Society

LONDON

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

TWENTIETH DAY

Thursday, 19th June, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

*MRS. K. M. C. BAXTER

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

SIR DAVID HUGHES PARRY, Q.C.

SIR HUGH WATSON, D.K.S.,
MR. S. WATSON, C.B.E.

MR. W. A. FULLER, D.S.C. (*Secretary*)

MR. J. B. HUME (*Assistant Secretary*)

Explanatory Note by the Royal Commission

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence, to all representative medical organisations:—

ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

- (i) The quality and quantity of recruits (a) offering themselves and (b) accepted for training as medical students.
- (ii) The quantity and quality of newly qualified doctors.
- (iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.
- (iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).
- (v) The position and prospects of a newly qualified doctor.
- (vi) Any trend to excessive resort to certain branches of the profession at the cost of others.
- (vii) The relative advantages and disadvantages, financial and otherwise, of service as:—
 - (a) a principal in single-handed general practice,
 - (b) a partner in general practice,
 - (c) a whole-time consultant in the National Health Service,
 - (d) a part-time consultant with the maximum number of sessions,
 - (e) a part-time consultant with only a few sessions,
 - (f) a Senior Hospital Medical Officer,
 - (g) a doctor in any other sort of practice or employment.

* Afternoon only.

- (viii) The difficulties encountered by members of the registrar grades.
- (ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.
- (x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.
- (xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.
- (xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service.
- (xiii) Any anomalies in the methods of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume.
- (xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.
- (xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.
- (xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.
- (xvii) Special considerations of which account ought to be taken in discussions of medical remuneration.
- (xviii) Specific proposals for medical remuneration.
- (xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.
- (xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.
- (xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

SCOTTISH ASSOCIATION OF MEDICAL ADMINISTRATORS

Evidence for submission to the

Royal Commission on Doctors' and Dentists' Remuneration

PREAMBLE

1. This memorandum is concerned solely with the remit of the Royal Commission as it applies to the terms and conditions of service of members of the Scottish Association of Medical Administrators. Our members work in the closest co-operation with their medical colleagues in all branches of the National Health Service and at one point in our discussions we considered submitting evidence covering a much wider field. Memoranda are, however, being submitted to the Royal Commission from all branches of the National Health Service and it now seems clear to us that no very practical purpose would be served by repeating evidence being brought before the Royal Commission from other and more appropriate sources.

2. We do feel, on the other hand, that there is a great need to clarify and re-appraise the position of Medical Administration in the National Health Service. This need is most clearly seen in reference to the position of the whole-time Administrative Medical Superintendents of Hospitals.

3. It will be found that in this Memorandum we keep coming back again and again to the position of these Medical Superintendents. What applies to them applies also very largely to Medical Administration in the National Health Service as a whole, and if the position of these doctors working in hospital administration is secured much will have been done to clarify and establish the position of Medical Administration in the National Health Service, at least so far as Scotland is concerned.

DESCRIPTION OF THE ASSOCIATION

4. The Scottish Association of Medical Administrators was founded* "to maintain and develop medical administration within the National Health Service; to provide opportunity for Medical Administrators to meet and discuss matters of clinical and administrative interest; and to foster training and instruction in Medical Administration."

5. Membership is open to Medical Administrators in Scotland from the Department of Health, the Regional Hospital Boards and the Hospitals. There are some eighty doctors eligible for membership and the main correspondence of the Association goes to them all. The paid up membership is forty-five. Meetings are held quarterly and are attended by up to forty members—the average attendance is twenty-five. The meetings are held in different hospitals in the five regions of Scotland in turn and opportunities are taken of seeing and discussing new developments as they occur.

6. The Council of the Association has a President, Chairman, Vice-Chairman, Secretary and Treasurer and ten ordinary members. They are chosen so as to be as representative as possible of the five regions and of the different kinds of Medical Administrator forming the membership of the Association. The 1956-57 Council has 7 Medical Superintendents, 2 Physician Superintendents, 2 Senior Administrative Medical Officers of Regional Boards, 2 from the Department of Health and 1 Deputy Medical Superintendent—geographically it covers 2 from the North-Eastern Region, 3 from the Eastern, 3 from the Western, 4 from the South-Eastern and 2 from the Department of Health. When appointed, one of the Council members was from the Northern Region but has since transferred. (Appendix A.)

HISTORICAL BACKGROUND OF SCOTTISH ASSOCIATION OF MEDICAL ADMINISTRATORS

7. The Association came into being in 1954. It was formed from the Scottish Branch of the Medical Superintendents' Society and when it was formed membership was widened to include in addition to Medical Superintendents,* "other Medical Administrators within the National Health Service."

8. The reasons for this secession are not hard to find. By 1954 the attitude to Medical Superintendents in England and Wales had become so different from that in Scotland that separation was the logical step. It was a step understood and agreed to by Medical Superintendents on both sides of the border.

9. By 1954, in England and Wales, Administration was coming to be regarded as a profession of which hospital administration formed a branch. This meant that a training in catering or accountancy with secretarial and administrative experience could form the basic training for a hospital administrator on which background he could learn whatever further skill and modification hospital administration might require. As a result of this attitude Medical Superintendents were being replaced in England and Wales by Lay Administrators. Bradbeer bears this out by the falling figures for Medical Superintendents (Bradbeer paras. 48 and 49) and in particular points out that by 1952 only eight full time Medical Superintendents were left in England and Wales.

10. In Scotland the feeling was and is quite different. Here we feel that since a Hospital is for the care of patients, and since the care of patients is a medical responsibility, medically trained men are best suited to administer the hospitals: in fact, that Medicine is a profession within which Medical Administration has a logical and recognised place.

11. The difference between the two systems has other features of importance. In England and Wales Medical Superintendents are still appointed to some hospitals. But such Medical Superintendents are not Medical Administrators in the Scottish sense. They are part-time administrators with a main interest in some clinical specialty. This concept of Medical Administration is made clear in Bradbeer⁽⁶⁾ para. 72, which says—"The medical administrator must be a consultant in active practice . . . we do not think he should be required to give more than a reasonable

* Extracted from the Constitution of the Association.

proportion of his time to administration". Now at once that lays the English system open to two charges. (1) It fails to recognise that the Medical Administration of a hospital or Group of Hospitals of any size is a full-time job and that to try to do it as a part-time job is likely to lead to it being badly done. (2) A consultant in clinical charge of cases in one section of a hospital when he is put in full administrative charge of the whole hospital is sometimes charged with seeking to exercise control over clinical practice throughout the hospital and this leads to friction with other clinicians.

12. It is on these grounds that Medical Superintendents are so frequently criticised in England and Wales and these are the arguments used even by the Consultants and Specialists in England and Wales for their frequent failure to support Medical Superintendents.

13. In Scotland the picture is quite different. Here in the General Hospitals the Medical Superintendent is a full-time administrator without clinical responsibilities. The Hospital Superintendents in Scotland who have clinical responsibilities are the Physician Superintendents of the special hospitals. It is of interest to note that the Bradbeer Report in discussing forms of Medical Administration in Hospitals discusses five different forms but none of these is a Medical Superintendent in the Scottish sense—a man who has chosen Medical Administration as his specialty and makes it his career.

14. In Scotland too it is important to remember that the Medical Superintendents enjoy the full confidence and support of the Consultants and Specialists. The Consultants and Specialists of Scotland in 1949 unanimously adopted a report on the position of Medical Superintendents which they have reaffirmed on various occasions since then.^(*) The following quotations from that report are pertinent. "The great teaching infirmaries from their foundation in the eighteenth and nineteenth centuries have employed a medically qualified person to superintend, on behalf of the managing body, the day-to-day running of the institution". "In the running of any major hospital purely medical problems must frequently arise which involve decisions which can only properly be taken by a qualified medical man". "It appears to us to be incontrovertible that such day-to-day decisions would require the authority of the executive head of the hospital". "We have, therefore, come to the firm conclusion that the medical superintendent ought to be the chief executive officer of the hospital or group of hospitals".

15. A recent publication of W.H.O.^(*) underlines the fact that in its continuance of Medical Superintendents as envisaged by the Henderson Report⁽⁴⁾ Scotland is in step with expert world thinking on the subject. In the "First Report of the Expert Committee on Organisation of Medical Care", W.H.O. in a paragraph on hospital administration we read:—

"The Committee were of opinion that for the overall administration of a hospital a physician was preferable to a layman."

and

"It was agreed that a physician administrator of a large hospital should be employed on a full-time basis preferably without clinical responsibilities."

(The relevant paragraph is quoted in full as an appendix—Appendix B.)

16. In Scotland there is considerable anxiety lest the present English system of lay administration be imposed on the Scottish Hospitals and a general feeling that the W.H.O. pronouncement should be given wide publicity so that it becomes clear that not in Scotland but in England and Wales the decision has been taken to march out of step with world opinion.

17. Another point of interest and contrast between the two countries is that while in Scotland we would seem to have established the status of Medical Superintendents and declared for their continuance, in England and Wales such part time Medical Superintendents as do continue have achieved a financial award which we have failed to do. The Bradbeer report recommends that where a Consultant is employed in Medical Superintendent duties "he should not be penalised financially for the time he devotes to Medical Administration work".

REPLIES TO THE ROYAL COMMISSION'S QUESTIONNAIRE*

18. In preparing the present memorandum the relevant questions from the questionnaire supplied were circulated to members of Council and the following extracts from replies may be of value.

iv. *The cost and duration of training for Medical Administration* in any form is that of a six-year M.B., Ch.B. course followed by a year's hospital experience before registration. To this must be added a further post graduate year for the D.P.H. course or some equivalent. For hospital administration there must be a further period of experience in hospital service of three to five years while experience in other branches of the medical service is desirable—a period of over twelve years training and experience, by which time the candidate is likely to be over 30 years old.

Where present occupants of posts in medical administration so desire, it would seem to be quite in accord with modern practice to suggest that leave with pay should be available to enable them to take the D.P.H. course.

vii. *The advantages and disadvantages of service as a Medical Administrator* have been put as follows. The main advantage to the individual is that Medical Administration offers to the doctor a wide field of interest demanding initiative, foresight and leadership. Within limits it permits freedom of action, absence of repetition and opportunity to exercise his clinical knowledge over the whole field of his superintendence. The main advantage to the service as a whole will be seen with proper recruitment when Medical Administration provides knowledgeable leadership mellowed by tact, good humour and strict impartiality. The disadvantages to the individual doctor are that at present medical administration is a relatively poorly paid career devoid of financial incentive. This is also a disadvantage to the service as a whole because it deprives the service of a valuable adjuvant to good recruitment.

In this connection the whole Henderson report is apposite and a copy is enclosed with this memorandum. Attention is particularly drawn to the recommendations on page 21.

xiii. In dealing with *anomalies in the methods of payment to Medical Administrators* the following points have been made. Medical Superintendence is a specialty by itself, born of long practical experience of handling medical and other staffs and patients in hospital, and dealing with the difficult situations that arise. This is not a procedure that can be laid down by any rule of thumb method by official regulations. It is a profession that calls for tact and human understanding, combined with a knowledge of the medical background against which such situations arise, together with a knowledge of official regulations; but these latter are only of importance as a guide to a Medical Superintendent to enable him to cope with his problems. They are by no means a solution of his problems. The solution can only come from his practical experience and knowledge. It is everywhere apparent in Scottish hospitals that the consultant staff regard the Medical Superintendent as of equal status. On these grounds it is contended that the salaries of Medical Superintendents ought to be at least the equivalent of that of consultants, and not as at the present time more than £1,000 less than consultants' salaries. This anomaly has already been pointed out in the introductory part of this memorandum, its remedy is strongly supported by the Henderson report, it is an anomaly which is seen in some degree in all forms of Medical Administration. It is worth repeating here that for England and Wales the Bradbeer report recommends (and these recommendations are carried out) that where a consultant does administrative duties he shall be paid for that service at the same rate as for his other sessions.

In the case of Physician Superintendents the Association would carry the case a step further. Here, in addition to his clinical work, the Physician Superintendent has administrative responsibilities and duties which can be more demanding even than his clinical work. Being resident he is more completely "whole-time" than

* Roman numerals correspond to the numbered questions sent by the Royal Commission.

other Medical Officers. He thus merits extra remuneration over and above his clinical colleagues and without such extra remuneration it will continue to be difficult to fill these posts.

xvi. With regard to *financial stringency* it is clear from what has now been said that Medical Administrators as a class have, up to the present, been treated as poor relations and in comparison with their clinical colleagues suffer financial stringency. A clear example of this disparity is seen in the fact that the top salary for the three highest Administrative Medical Superintendents in Scotland is £1,000 less than the top of the Consultant salary scale without Merit award. In the days before the National Health Service the Medical Superintendents were more adequately paid and often had in addition to their salaries a free house with light and fuel and, especially in Teaching Hospitals, an entertainment allowance.

xvii. *The special considerations to be taken into account when thinking of the remuneration and recruitment of Medical Administrators* and especially of Hospital Superintendents, include these: the Medical Superintendent is a specialist requiring sound clinical knowledge so that he can fully appreciate the outlook of other members of the Medical profession whether in hospital, public health or general practice; the Medical Superintendent is the person in hospital who carries ultimate responsibility. Other considerations mentioned by members are the Medical Superintendent's responsibility for entertainment, the length of his experience and training and the high ethical standards very properly required of these officers.

There is considerable anxiety about the future recruitment of the right kind of doctors for Medical Administration. It is felt that the establishment of some three training posts in the Hospital Service in Scotland to give insight into the work at Departmental, Regional and Hospital levels will help this, but again the question is clearly related to promotion prospects and salary scales and there is an obvious need for promotion which is both competitive and rewarding.

xviii. *Specific proposals for the remuneration of full-time Medical Superintendents* in the General Hospitals of Scotland have been prepared. These proposals can well form the basis of scales for other grades of Medical Administrators.

In Scotland the responsibilities of these Medical Superintendents were assessed on the number of beds in the hospitals and the number of individual hospitals under his care. On this basis the general hospitals were graded into 6 classes. The present salary scales for these classes are given in an appendix to the Henderson report. Following the issue of that report the Scottish Association of Medical Administrators prepared fresh scales to conform with recommendation 6 (Henderson report page 22).

"The salaries of Medical Superintendents in hospitals should be increased so that the amount paid to the posts of greatest responsibility compare broadly with the salaries paid to consultants".

In drawing up these scales the Association has accepted for the present the existing grading of hospitals. The scales prepared are as follows:—

Group 1.	(3)*	£2,750 x 100—3250.
Group 2.	(3)	£2,650 x 100—3150.
Group 3.	(7)	£2,550 x 100—3050.
Group 4.	(9)	£2,350 x 100—2850.
Group 5.	(3)	£2,050 x 100—2550.
Group 6.	(2)	£1,850 x 100—2350.

These scales are based on consultants' salaries as at April 1st, 1957, and should be subject to revision so that the ceiling scale in Group 1 rises as that of the Consultants rises and that the ceiling scale in Group 6 remains appreciably higher than the ceiling for S.H.M.O.'s.

The Deputy Medical Superintendents are at present paid on a scale of two-thirds that of the corresponding Medical Superintendent and no change to that relationship is at present proposed.

* The number within the brackets is the number of appointments in that group.

xx. In considering the *arrangement for negotiating salaries* it is contended that this Association should be included in the machinery for discussions and negotiations. It is also stressed that the salaries of all medical officers within the hospital service should continue to be considered by one and the same Whitley Council.

xxi. In commenting on *factors other than remuneration* which are affecting the contentment of doctors working in the sphere of Medical Administration, two points were brought out: they have financial implications and so are perhaps not totally unrelated to remuneration.

(1) There still are anomalies in respect of charges for emoluments and amenities—a more liberal attitude in such apparently small matters would be well worth while. Some of these anomalies are inevitable but it is felt in particular that where a Medical Superintendent is expected to entertain Hospital guests he should have an entertainment allowance.

(2) Some members have felt a certain insecurity of status and while this will be clarified if the Henderson report is implemented, especially in regard to recommendation 4 which says that the Medical Superintendent 'ought to be the co-ordinator of all activities within the hospital' there are many who maintain that status cannot be dissociated from remuneration and that to maintain his position as Superintendent and Co-ordinator the occupant of such a post must be properly rewarded financially.

COMMENT

19. In spite of the support for Medical Superintendents given by the Scottish Consultants and Specialists, the Guillebaud report, the Henderson recommendations and the W.H.O. documents quoted in Appendix B, there still is anxiety in Scotland lest the English system of lay administration be imposed on the Scottish Hospitals.

20. The Henderson report in paragraph 15 fails to make the Scottish position in this matter clear. That paragraph states that 22 Hospital Groups out of 84 have medical superintendence and so the paragraph concludes "it can be seen that at present only a minority are directly concerned with the appointment of administrative medical superintendents". The statement as it stands is true but the comparison of 22 Boards with 84 as the possible number is misleading and might even suggest that 75 per cent. of the Boards in Scotland have lay administration.

21. How far this is from the true position will be seen at once when we remember that the 84 Boards mentioned include Boards with responsibilities in outlying and island communities, 2 Boards which are Dental Boards and have no hospitals, 2 Boards of Special Hospitals which have Physician Superintendents and 24 Boards of Mental Hospitals and Mentally Defective Institutions which also have Physician Superintendents.

22. A much better way to appreciate the overall position in the Scottish Hospitals is to consider the method of administration in relation to the number of beds administered. This is done in the table in Appendix C which shows that up to the present, nearly all hospitals in Scotland of 250 beds and over are in fact medically administered and that 88 per cent. of the beds in general hospitals or 93 per cent. of all hospital beds in Scotland are medically administered.

CONCLUSION

23. This Memorandum serves to show that Medical Administration is a medical specialty within the profession as a whole and performing a valuable function within the National Health Service.

24. The recent report prepared for the Department of Health for Scotland on "Medical Superintendents and Medical Staff Committees" (The Henderson report) agrees with our contentions. The evidence of our Memorandum is also unreservedly supported by the Scottish Consultants and Specialists and by the World Health Organisation Expert Committee.

25. It is our contention that the recognition of Medical Administration as a specialty in its own right is overdue and as a logical step towards that recognition we submit more adequate salary scales for whole-time Administrative Medical Superintendents and a proper career structure for Medical Administrators throughout the National Health Service.

REFERENCES

- (a) Bradbeer: "A report on the Internal Administration of Hospitals" England and Wales. H.M.S.O. 1954.
- (b) Central Consultants & Specialists Committee (Scotland): "Report on the Position of Medical Superintendents in the National Health Service". 1949. See also a re-affirmation of this in the Annual Report of the Central Consultants & Specialists (Scotland) 1956.
- (c) W.H.O. Technical Report Series, No. 122, 1957. "Role of Hospitals in programmes of community Health Protection". Quoted also in the Chronicle of the W.H.O. June-July, 1957.
- (d) Henderson: "A Report on Medical Superintendents & Medical Staff Committees". Scotland. H.M.S.O. 1957.

APPENDIX "A"

Members of Council

Sir ANDREW DAVIDSON (*Hon. President*),
Ex-Department of Health for Scotland.

Dr. S. G. M. FRANCIS (*Chairman*),
Group Medical Superintendent,
Royal Infirmary & Associated Hospitals,
Edinburgh.

Dr. C. BAINBRIDGE (*Vice-Chairman*),
Senior Administrative Medical Officer,
Eastern Regional Hospital Board,
Dundee.

Dr. P. W. R. PETRIE (*Secretary & Treasurer*),
Deputy Medical Superintendent,
Royal Infirmary & Associated Hospitals,
Edinburgh.

- Dr. J. MORRISON, Group Medical Superintendent, Special Hospitals, Aberdeen.
- Dr. W. MACKIE, Group Medical Superintendent, General Hospitals, County and City of Perth.
- Dr. A. K. M. MACRAE, Physician Superintendent, Bangour Mental Hospital, Broxburn, West Lothian.
- Dr. A. MENZIES, Medical Officer, Department of Health for Scotland.
- Dr. A. D. BRIGGS, Medical Superintendent, Stobhill Hospital, Glasgow.
- Dr. W. A. MURRAY, Physician Superintendent, East Fortune Hospital.
- Dr. F. D. BEDDARD, Senior Administrative Medical Officer, North-Eastern Regional Hospital Board, Aberdeen.
- Dr. J. K. ANDERSON, Medical Superintendent, Royal Infirmary, Glasgow.
- Dr. G. H. SCULAR, Group Medical Superintendent, North and South Ayrshire Boards of Management.
- Dr. J. M. CUTHBERT, Medical Superintendent, Angus, Stracathro and Brechin Boards of Management.

APPENDIX "B"

WORLD HEALTH ORGANISATION TECHNICAL REPORT SERIES No. 122

ROLE OF HOSPITALS IN PROGRAMMES OF COMMUNITY HEALTH PROTECTION

7. ADMINISTRATION AND ORGANISATION

page 23

7.—(1) *The Hospital Administrator and hospital staff*

The Committee noted that in a certain number of countries hospital management is carried out by non-medical administrators, usually trained at commercial or business schools. In other countries, hospitals are administered by physicians with special administrative experience, and it was mentioned that at least in one country a public health degree was necessary in order to become director of a general hospital. The Committee was of the opinion that, for the overall administration of a hospital, a physician was preferable to a layman. Among the arguments advanced in support of this contention was that a medically qualified administrator would tend to enjoy greater confidence and respect and therefore closer co-operation from all the professional staff who have direct contact with the members of the community seeking help and guidance. He would also better understand the needs and problems of a hospital service and would, in consequence, have the best chance of arriving at satisfactory decisions.

It was, however, recognised that a large part of the day-to-day administration of a hospital is concerned with what were called "house-keeping" duties which are essential for the overall management of any establishment catering for human wants. The Committee thought that this aspect was often unduly stressed, important though it admittedly is. A medically-qualified hospital administrator could nevertheless be assisted by a fully-trained lay hospital administrative assistant who could be responsible for these duties. On the other hand, an administrative committee could be organised to assist the hospital administrator to discharge these duties. It was recommended that a senior nurse should always be a member of such a committee.

It was agreed that a physician-administrator of a large hospital should be employed on a full-time basis, preferably without clinical responsibilities, and he should be adequately trained in hospital administrative techniques. It was also emphasised that a careful evaluation of candidates for hospital administration training should always be made to ensure that medical trainees who have a "flair" for administrative and public health work are selected.

APPENDIX C

HOSPITAL BEDS IN SCOTLAND AND THEIR METHOD OF SUPERINTENDENCE IN
RELATION TO THE SIZE AND TYPE OF HOSPITAL

The figures used here are taken from the 1957 edition of the
Hospitals Year Book

Size and Type of Hospital		With full-time Administrative Medical Superintendents		With Surgeon and Physician Superintendents		With part-time Medical Superintendents		Others	
		No. of Hospital	Total beds	No. of Hospital	Total beds	No. of Hospital	Total beds	No. of Hospital	Total beds
Over 500 beds	General	16	12,836	3	1,899	—	—	1	796
	Mental	—	—	20	20,483	—	—	—	—
250 but under 500 beds	General	17	5,467	1	362	—	—	—	—
	Mental	—	—	9	3,560	—	—	—	—
100 but under 250 beds	General	42	6,161	4	798	7	1,003	10	1,637
	Mental	—	—	12	1,985	—	—	—	—
50 but under 100 beds	General	35	2,446	7	453	9	575	13	894
	Mental	—	—	1	71	—	—	—	—
Under 50 beds	General	84	2,188	3	106	33	731	61	1,410
	Mental	—	—	6	116	—	—	—	—
TOTALS	General	194	29,098	18	3,618	49	2,309	85	4,737
	Mental	—	—	48	26,215	—	—	—	—

Thus:—(i) Of 65,977 hospital beds in Scotland under the National Health Service, only 4,737 are without Medical Superintendence, i.e., 7 per cent. of the total.

(ii) Of 39,762 hospital beds in Scotland exclusive of the Mental Health beds, 29,098 are administered by whole-time Administrative Medical Superintendents, i.e., 73 per cent., and of the remainder a further 15 per cent. is medically administered either by part-time Medical Superintendents or Physician Superintendents.

Examination of Witnesses

DR. S. G. M. FRANCIS, *Chairman of the Association*

DR. C. BAINBRIDGE, *Vice-Chairman*

DR. F. D. BEDDARD

DR. W. MACKIE

DR. P. W. R. PETRIE, *Honorary Secretary and Treasurer*

on behalf of the Scottish Association of Medical Administrators

Called and Examined

4810. *Chairman:* Dr. Francis, as Chairman of the Scottish Association of Medical Administrators you will be acting as the principal spokesman, will you?—*Dr. Francis:* We discussed this this morning, Sir, and although I can act as spokesman if you like, I would prefer just to direct the batting order because I do not want to do all the talking.

4811. You will find questions being shot at you from any member of the Commission on these matters, but principally from Sir Hugh Watson, who has been the Chairman of the Subcommittee which has considered this particular batch of evidence. I must remind you that this is a public session, so anything which is said is liable to appear in print, at any rate in the printed evidence which we will eventually produce. You are concerned with a particular point and we intend to try and keep it to the rather narrow issue which affects administrators in particular. We may have to go a little to one side or another of that. That therefore means we do not expect to cover every point you have raised in your memorandum, but I hope you will not think that those we do not cover are necessarily either accepted or considered irrelevant, because of course we have covered much of the ground with other bodies from time to time. Equally of course, as you probably know, if we do not question you nobody else will, and so we shall question you perhaps rather firmly. You are not to take that as implying any kind of hostility.—No, Sir, we will not.

4812. Would you mind first, for the purposes of the record, describing your Association and its coverage, membership and so forth?—The Association has been in existence now for four years, and it was formed by our agreeing amongst ourselves to dissolve the Medical Superintendents' Society, Scottish branch,

and reconstitute ourselves into a Scottish Association of Medical Administrators. We now embrace doctors in the Department of Health who are interested in the hospital side of the Health Service, Regional Board medical officers and administrative medical superintendents of Scottish hospitals, as well as physician superintendents such as we have in mental hospitals or in tuberculosis sanatoria.

4813. How many members have you?—The paid-up membership is about 50.

4814. And how many could there be?—Eighty-five.

4815. *Sir Hugh Watson:* What exactly do you mean by the paid-up membership?—We look upon that as the active membership of the Association, Sir. If people pay their subscriptions we reckon they are really active functioning members.

4816. So out of the possible 85, you have got 50 members who take a really active and live interest in your body?—Yes. We send our circulars to all the appropriate people in Scotland, but of course the balance of 30 largely consists of general practitioners who are acting as medical superintendents in small cottage hospitals in rural Scotland.—*Dr. Petrie:* Not all the mental hospital superintendents are paid-up members.

4817. *Chairman:* What proportion of the 85, roughly, would be in mental hospitals?—*Dr. Francis:* It would be fair to say, Sir, that we have got good representation from the Regional Boards, and the administrative medical superintendents to a man support us very strongly. As we say, not all the physician superintendents of mental hospitals are members; they have their own association which was in existence long before we

started. The rest are I think general practitioners who cannot get away to come to our meetings.—*Dr. Petrie*: There are 24 Boards of mental hospitals and there are 22 Boards of general hospitals; there are several mixed.

4818. *Sir Hugh Watson*: We know from the papers which you have been good enough to give us that there are differing views about the way in which hospital administration should be dealt with in England and in Scotland. As you appreciate, the Commission are not concerned to enquire into the merits of these two views; for this purpose the Commission I think are prepared to accept that the one method is adopted in Scotland. They would like, to enable them to appraise the remuneration appropriate to the people who carry on that administration, to find out something about exactly what these doctors do and how in fact the hospitals are administered. In your paragraph 10 you say: "since a hospital is for the care of patients, and since the care of patients is a medical responsibility, medically trained men are best suited to administer the hospitals; in fact, that Medicine is a profession within which Medical Administration has a logical and recognised place". That is your philosophy about this matter is it?—*Dr. Francis*: Yes, Sir.

4819. Would you like to expand that and tell the Commission just why you feel that hospitals ought to be administered by doctors rather than by lay administrators?—I would like to answer this question if I may by asking *Dr. Beddard*, who is an Englishman who worked in the National Health Service in England and who is now with the North Eastern region, to answer that on behalf of the Association, as he has experience of both methods of administration.

4820. In that case could I ask *Dr. Beddard*, do your Association agree with the summary of the duties of the office set out in paragraph 133 of the Henderson report?—*Dr. Beddard*: Yes, we do, Sir.

4821. So we can take it these really are the duties of the medical superintendent in Scotland?—Yes, I would say so.

4822. What are the relations of the medical superintendent to his Board?—It varies to some extent from Board to

Board, in my experience, but generally speaking in Scotland he is at the moment considered to be the chief executive officer, that is to say, he is expected to keep an overall picture of what is going on in the hospital and to take decisions on his own responsibility on all matters affecting the patient, except matters concerned with finance. That is perhaps a generalisation, as it varies I think from Board to Board.

4823. I do not want to interrupt you, but what exactly do you mean by saying "all matters in connection with the patient", because as I understand it the medical administrator has no clinical responsibility?—I meant of course all matters concerned in the administration of the hospital which have a bearing on the patient. That would include such things as the organisation of out-patient departments, records, and catering, which one might consider was a purely lay activity. In fact the medical superintendent is expected to take a considerable interest in the catering of the hospital, because it directly affects the patient. The financial arrangements, the budgeting, do not come into his sphere except in so far as hospital medical equipment is concerned. The amount of interest the medical superintendent takes in the purely domestic affairs of the hospital, the engineering services, the domestic services and so on, varies to some extent and I think many of us feel that in some hospitals the medical superintendents should be able to off-load some of that work on to lay administrators. I think most of them now try to do so. I think it would be true to say—although this is rather before my time—that traditionally the medical superintendent was concerned in the past much more than he is now even, with those sorts of matters.

4824. You mean he had to give directions for the stoking of the boiler, and that sort of thing?—Yes, but that is not the position now, and it certainly would not be our case that those duties should fall to the medical superintendent.

4825. Perhaps it would help if for the purposes of the record I just quote paragraph 33 of the Henderson report very shortly. In the view of the Henderson Committee the functions of the medical superintendent were as follows: (1) "He ought to be in a position to advise the Board about the most effective use of the hospital resources . . ." (2)

"general supervision of the junior medical staff, pharmacy, and medical auxiliaries." (3) "supervision and organisation of the out-patient department." (4) "Advise on hospital planning, furnishings and equipment." (5) "Liaison with administrative officers of the Regional Hospital Board . . ." and (6) "Co-operation with the Dean of the Faculty of Medicine about the provision of teaching facilities". These are the principal functions. I suppose one of the most important of these is the supervision and organisation of the out-patient department, at least so far as the patient is concerned?—Yes, Sir, that is a major operation which has to be done. If it is once organised effectively it requires not a lot of the superintendent's time to keep the machinery in motion, but that is certainly a thing which he has done and does do.—*Dr. Francis:* I wonder, Sir, if I might come in at that point? I did ask Dr. Beddard to speak to this on our behalf because I was under the impression at that time that you were discussing the differences between Scotland and England, and as he has experience of both methods I thought he could bring out these points from his experience. If you want to know the duties of the medical superintendent, as in fact they are carried out, I would ask—

4826. I do not think we want to be drawn into a controversy as to which is the best way of doing the thing. I think for the present purpose the Commission is prepared to accept that a certain method is in fact used in Scotland. What we want to find out really is how in fact hospital administration in Scotland is carried out.—If we could, in addition to the paragraphs you have read out from the Henderson report, mention that there is also paragraph 7 which is of the greatest importance—

4827. Yes, if you please. " . . . he ought to be a co-ordinator of all the activities in the hospital " ?—Yes, Sir, we consider that is fundamental to the good running of the hospital.

4828. Then in the next paragraph " . . . we do not think it desirable that a medical superintendent in carrying out the functions listed above should be responsible for example for gardens, porters, maintenance staff or laundry though he may be concerned with these services from time to time as an aspect of his co-ordinating responsibility . . . "—Yes, Sir.

4829. What are the relations of the medical superintendent with the medical staff?—The relations, I think, in my experience and the experience of my colleagues, are extremely good. You have a two-way function with the staff. First of all, they have in Scotland a very well organised system of medical staff committees. The system varies from hospital to hospital depending on its size, but fundamentally it is the consultants getting together and, ambitious for the improvement of the hospital, putting up proposals for the improvement of the hospital service. These proposals come to the Board of Management, and they are discussed at that Board of Management. They have direct access to the Board, but in actual fact find it very convenient to do it through the Superintendent; so that our relations with the staff are in the form of information and help coming upwards to the Board, and then transmitting the views of the Board downwards to the staff again. There is a two-way traffic in our relations with the staff. It is a very wide relationship, because not only is there the formal business of the Board to discuss with them, but there is a great deal of day to day sorting out of problems, medico-legal problems, the question of closing wards because of infection. Any worries at all which the consultant has, he can come and discuss with the Medical Superintendent, because one of the strongest things about our position is that, having no clinical responsibilities at all but having had a good basic training before we got these jobs, we can help enormously in the day to day problems which are a little out-with their province as doctors entirely in charge of the patients. The clinician in Scotland has complete professional integrity and independence to look after his patients; the Secretary and Treasurer has complete professional integrity and independence to look after his budgeting, his Board minutes, and the general business management of the hospital—all these things which are mentioned in the Henderson Report which are not strictly speaking the Superintendent's responsibility. But the final co-ordination of all that on behalf of the patient rests with the Superintendent acting for the Board of Management. The position is very much like a ship which is going out to India and back again: when the ship is in port at Tilbury it belongs to the P. & O. Company, but when it is at sea

it is the captain's responsibility. During the days between the meetings of the Board of Management somebody has to set the ship's course on behalf of the company, and that is what the Superintendent does. A lot of day to day decisions have to be taken; you have got to be right on your toes; you have got to know where you are going; somebody has to carry the can.

4830. Then in practice how is the day to day management of the hospital divided between the Medical Superintendent and the Secretary?—The Secretary is responsible for the minutes of the Board of Management, letters from the Board on their behalf to other outside bodies, except where they are purely medical letters. He is custodian of the funds, secretary and treasurer. In addition to that he is what we loosely describe as the business manager of the hospital; he looks after the question of contracts for provisions, and so on, and, for example, he would be responsible for the house steward's department and the works department, and everything that does not fit into the Medical Superintendent's duties. For instance, if you were ordering new sterilisers we would be involved in choosing the type of steriliser in association with the clinicians who were interested in a particular pattern; and when the final pattern had been chosen and approved by the Board the Secretary would place the contract for its provision.

4831. *Dr. Francis*, in sub-paragraph xvii on page 1040 of your memorandum you say: "The Medical superintendent is a specialist requiring sound clinical knowledge . . . the medical superintendent is the person in hospital who carries ultimate responsibility". What exactly have you in mind by that expression?—The analogy with the captain of the ship is really what I have in mind, that is exactly what the position is. The Clinician has responsibility for the actual treatment of his patient, complete independence to carry it out in any way he thinks best; the Secretary and Treasurer has his responsibilities with finance, secretarial work for the Board; but the final responsibility for things going wrong comes back to the Superintendent. We deal with all complaints, we have to rise to the occasion and cope with all emergencies. I can give you two examples of the sort of thing I

mean—it might help the Commission to appreciate the position because I do not want to talk of generalities; they mean nothing to people who do not know the form in hospitals at all. But I would like, if I may, to give you, say, two examples which have happened to me, which are completely apposite I think. One was on a particular Saturday in Edinburgh when we were under extremely heavy pressure on the medical side. It was in the early part of the winter and the medical beds were very overloaded with patients; we had extra beds up in every single ward. We were very heavily stretched, and particularly short of beds for male medical cases. That day I rang up the Bed Bureau in Edinburgh and explained our difficulty; they agreed to send all medical emergencies, the males, to a hospital in West Lothian and give us a chance to recover from the large number of patients we had. That worked very well; I was quite happy about it. But unfortunately that afternoon Hearts were playing Rangers, there were two quick goals in three minutes, and we had five coronaries—three of them were in the crowd, one man was going through the turnstiles and the other was just walking about. These people were brought straight out by the police to the Edinburgh Royal Infirmary. There literally were no medical beds for them at all; extra beds were put up in the middle of all the wards. I was told about this, and I went straight over and saw them, though I had no clinical responsibilities. The doctor doing the admissions was desperate, and told me so. I then said: "Can I see the surgical bed state?" I checked the surgical ward, which had some empty beds, because it was getting ready for its take-in day on Monday, and I admitted these cases to the surgical side at Edinburgh Royal. I realised it was necessary and arranged for extra staff to be seconded to look after them, and then as we got vacancies in the medical side due to deaths over the week end, they would be transferred. Having done that I then rang up the surgeon whose beds they were and said I was very sorry about this but we had to do it, and I hoped the beds would be cleared by the Monday when his cases were coming in for operation on Tuesday. The first case died 40 minutes later; the second one died that night, the third one on Sunday, and the other two were transferred. If we had sent these cases on to

another hospital these three would certainly have died in the ambulance, and we might have lost the lot. The two points about that were that a decision was taken by the senior administrative officer of the hospital which definitely saved lives, and secondly that the senior clinical staff accepted that position; they would have thought me a very bad Superintendent if I had not done it. That is a very good state of affairs, that a surgeon will agree to such a procedure.

That is one example. Another example was in the middle of the night, about 1.30 a.m. We had a failure in the heating services, and we got a great deal of hot water and steam being pushed through the cold water services. There was a flood, and of course it happened in one of the surgical wards. There was a tremendous flood with steam and hot water pouring all over the place, and the ceiling came down. I came straight across got hold of the duty room and found out which surgical ward was getting empty for its next day's admissions, rang up that surgeon, said we would have to bring him into commission straight away, and use his beds for the admissions that were really due for another ward. We actually coped with this, where a ward was completely flooded out, without even stopping the admission of surgical emergencies—and when I say that, the surgical emergencies in any one night in Edinburgh Royal amount to about 16 to 20, and it meant we really had to get moving. These are two examples of where, quite fortuitously, immediate decisions had to be taken; and they had got to be taken by somebody.

4832. *Chairman*: What I am not quite clear about is whether those decisions would have been taken in exactly the same way, just as quickly, just as efficiently and just as much accepted by the surgeons in charge of the surgical wards, if for instance, it had not been a clinically qualified man who did it?—*Dr. Petrie*: I think the examples Dr. Francis has chosen are very good ones, and I do not think the medical staff would accept these decisions so well if it had not been a clinically qualified man. But there are other cases where it is a matter of judgment requiring knowledge of infectious disease, where a case of dysentery occurs in a ward and one has to take a decision as to whether this is something which has come in and has not

infected the rest of the ward, or whether one must close the ward. That decision too must be taken quickly, and I am quite sure that it is better taken by a medical man.

4833. *Sir Hugh Watson*: You mentioned these two appropriate instances, Dr. Francis, as typical of what you regard as the ultimate responsibility of the hospital administrator. It is in that sense, in the sense of being responsible for making emergency arrangements and that sort of thing, that you regard you and your colleagues as having the ultimate responsibility?—*Dr. Francis*: Yes.

4834. We have heard a great deal from other branches of your profession about the training and, as it is put in the higher spheres, the very severe discipline which they have to undergo to qualify for their particular branches of your profession. As I understand it from your paragraph 18 (iv), to commence a career as a hospital administrator, according to the Scottish practice all that one requires—and I am not in any way belittling the qualification—is a degree as Bachelor of Medicine and Bachelor of Surgery with possibly a D.P.H. qualification to follow, is that right?—Yes, Sir.

4835. In your paragraph xvii which I have read already, you describe the medical superintendent as a specialist; are you describing him as a specialist in the sense that a consultant is a specialist, for instance?—A consultant, Sir, has naturally to have his Fellowship or his Membership, and he has a higher qualification in either medicine or surgery, or whatever his particular branch of medicine is, and I agree that on that basis we would not be in the same category, from the point of view of having passed examinations, as a surgeon or a physician. But I think that the training for Medical Superintendent, if he is going to be any good at all, is just as long and just as difficult to accomplish, and needs certain qualities which I think are worth appreciating. I think you do not want men to go in for medical administration when they are too young. I think they must have had a very good clinical training indeed so that they are able to understand the problems of a hospital. We do not want boys of 25 going in for this sort of thing, and we do not want men who have not got a natural aptitude for it, because it is a

very difficult thing to do. It needs an awful lot of tact, it needs an awful lot of understanding and infinite patience, and a very flexible sort of mind in dealing with things which crop up. But a man who has had a good clinical training, who has been, say, registrar or senior registrar and who in his early thirties finds he has an aptitude for medical administration, I think he should then be seconded. There are all sorts of proposals in the Henderson Report for the training of Medical Superintendents, and in fact I actually take part in this training and Dr. Petrie and Dr. Mackie take part as well; St. Andrews University in Edinburgh give lectures on the subject. But I think a man should embark on a provisional training as potential Superintendent or Administrator in a Regional Board, and then if he shows an aptitude for it and is any good at all he can move on. But the fact that we do not actually take our Fellowships or our Memberships, though many of them have them now, I do not think is a bar to considering this as a specialist profession. It really is a most difficult thing to achieve.—*Dr. Bainbridge*: I think, Sir, the problem is that there is no examination, no qualification or degree which is really applicable to medical administration. I think we have really got to try and compensate for that lack of a specific qualification by the length and breadth of the experience which a Medical Administrator has before he takes his Superintendentship or a post in a Regional Board. Apart from hospital work, a person who is undertaking medical administration should have some experience and knowledge of conditions outside the hospital. Really if possible a spell in general practice is often of considerable advantage to a person dealing with medical administration, because then he knows what are the home circumstances and conditions from which patients come and may be returned to. I think the nearest qualification we have is the D.P.H., which admittedly on calibre does not compare with the Fellowship or Membership of the Royal College of Physicians or Surgeons, but it really is the only degree which does embrace an element of administration.—*Dr. Francis*: In the United States and Canada of course there are training courses for medical administration.

4836. In Canada are hospitals largely administered by medical men?—Yes, Sir. I think the position here is that there is a curious historical and geographical distribution about medical administration. I think the best way of looking at it is that hospitals which were founded by the Church tend to have lay administration, because it may be that the lay secretary is the lineal descendant of the abbot, but in those countries where hospitals were founded by the profession they tend to have medical administrators. Hospitals in Scotland, for example, were founded after the Reformation, because at the time of the Reformation what hospitals there were just disappeared; but the hospitals in Scotland were founded after the Reformation and they have medical superintendents. And you find for instance that in Belgium and France and further south there tends to be lay administration, but in Holland there is medical administration. I do not know if it is an advantage to us that Russia has medical superintendents, but they do. The British Dominions do, and so does the United States. In the United States it is not a hundred per cent., nor is it in Canada, because they have difficulty in getting men of the required calibre, but the position is that where they can get medical men they like to have them, and in fact they have training courses in New York and in Toronto specifically for training medical administrators for these posts. An instance of where they have changed their minds is Chile; there the Church did found the hospitals but they have changed to medical administration because they found it more efficient. The position is that in the civilised world far more countries have medical superintendents than do not.

4837. *Chairman*: But most of them do not have them universally?—Holland has them universally and they are employed in the major teaching hospitals in Canada.—*Dr. Petrie*: I think Portugal has them universally, too, Sir.

4838. And usually if you are once a Medical Superintendent do you remain as such, or do you come back to having a different kind of job, a consultant, for example, with clinical responsibilities?—*Dr. Francis*: No, Sir, I look upon being Medical Superintendent of Edinburgh Royal as top of the tree; it is a wonderful job.

4839. Yes, but in general terms do Medical Administrators come to the top of their particular tree and then transfer, or not—not necessarily going up but transferring to another tree?—Unless that tree was also in administration, they would not, Sir. Obviously if they had been administering a hospital for ten years they could not go back to gynaecology or anything like that. I think if they are any good, once they are in it they stay in it.—*Dr. Petrie*: They could go on to other administrative departments.

4840. But once they have lost the power to make use of their clinical training, they never get it back, is that right?

—*Dr. Francis*: That is a curious question, Sir, if I may say so. They have not really lost it. They cannot be a good Superintendent of a hospital unless they are doctors, I am quite certain of that.

—*Dr. Petrie*: I think the point is that they have widened their field, and because they have not narrowed it they are not therefore likely to go back again to consultant practice. It is the width of knowledge that is required in medical administration rather than the narrowness required in specialisation.—*Dr. Francis*: I think the only reason they have changed from being medical superintendents is because of the force of the financial stringency.

4841. *Sir Hugh Watson*: That leads on to the next question. In subparagraph xvii, which we have looked at already, you say: "There is considerable anxiety about the future recruitment of the right kind of doctors for medical administration". Can you tell us a little about that? You have told us that your desideratum is that you should have recruited into your service a doctor preferably with a D.P.H. qualification who has had something like ten years of experience either in hospitals or in general practice. Can you tell us about your recruitment?—I think that the men are there, there are men of first-rate quality who are prepared to come forward, but the opportunities financially are so bad just now that they are hanging back. We have had many enquiries from men who would like to take up medical administration but we feel that the present prospects are so poor that they simply cannot consider it. I think, *Dr. Mackie*, you have a little experience in recruiting deputy Superintendents?—*Dr. Mackie*: No, it is a question really

of not filling the deputy's post until we know what is going to happen in the future to Medical Superintendents. I deal with a group of hospitals, Sir, rather than one individual hospital.

4842. *Mr. Gunlake*: You mentioned just now, *Dr. Francis*, formal educational courses in medical administration; can you say to what extent they are the rule or the exception in the civilised world?

—*Dr. Francis*: I only really know about Canada and the United States. We have started doing it in Scotland, but it is really only beginning.

4843. That is what I was going to lead up to—whether it was being considered in this country, and whether it might not ease the recruitment problem if such courses did in fact exist?—I think it would ease the recruitment problem up to a point, Sir, but there are two things about this: first of all I still think that even though you have a good training period the man will still learn best as an apprentice. I do not think you can learn from the book, and I think it would be a great pity if a degree or fellowship were given in medical administration and the man then became a Medical Administrator just because he got through his examinations. It is a little wider than that. The second part of the problem is that I think you will not get good men to come forward unless they are going to get a reasonable chance of supporting a proper standard of living and competing with their other professional friends.

4844. *Sir David Hughes Parry*: I take it that only those who are medically qualified are allowed to join the courses which you mention?—Yes, Sir.

4845. *Sir Hugh Watson*: You feel that at the moment the remuneration that is open in this particular service is a definite deterrent?—Yes. The position, Sir, was that when we put in our memorandum, I and the Medical Superintendents of Glasgow Royal and Glasgow West, who look after the three top jobs in Scotland, with the biggest responsibility and naturally the biggest salaries, at that time were paid £1,000 a year less than an ordinary consultant of whom I was administratively in charge. The disparity is a little less now because we had an increase of about 5 per cent. But there is no inducement at all to take on the very wide and worrying work which being Superintendent of a big hospital

entails, when in fact all your colleagues are getting £1,000 a year more than you are—and that is a straightforward consultant's job without merit award. It is pretty disheartening.

4846. Let us examine this question of remuneration, then, Dr. Francis. The remuneration of your particular branch up till now is regulated by Whitley B, is that right?—Yes.

4847. And the scale of remuneration for Medical Superintendents in Scotland is set out in Appendix B of the Henderson report on page 24?—Yes, Sir.

4848. That table discloses that the Medical Superintendents are divided into six grades, I think that is right?—Yes, Sir.

4849. And as you rightly say, Glasgow Royal, Glasgow West and Edinburgh Royal are in the top grade.—Yes.

4850. The top salary which can be achieved by the Superintendent of any of these hospitals is £2,250?—Yes, Sir.

4851. Whereas the salary of a consultant without merit award at that time was £3,100?—Actually, Sir, if I could just interpolate there, just so that we are honest about it, at the time we put in our memorandum the consultants had had their 5 per cent. increase to £3,250—you could check the dates to see if I am right, but I am certain I am—and we were actually £1,000 a year behind them at that time. But it is a small point when you are talking of £850 or £1,000.

4852. These scales of course were the result of negotiations in Whitley B and no doubt those representing you pressed from the Staff side the arguments as far as they could for increased remuneration?—Yes, Sir.

4853. And this was the most that you could get? The Henderson report in its recommendation 6 recommended that the salaries of Medical Superintendents of hospitals should be increased so that the amounts paid to the posts of greatest responsibility compare broadly with the salaries paid to consultants?—Yes, Sir.

4854. The amounts paid to the post of greatest responsibility—I suppose these are the three to which you refer?—Yes, Sir.

4855. I do not know what "compare broadly with the salaries paid to consultants" means.—I wonder, Sir, if

I could put this into perspective a little? You mentioned Whitley. The position about Medical Superintendents is that in Scotland—and I am only talking about Scotland, because that is all I know about in this particular connection—the British Medical Association and the consultants and specialists and the profession generally have always supported us very strongly, and have always supported the idea that we should get paid a reasonable salary in comparison with our professional friends. About eight years ago—it might be seven, I am not just certain, but I think it was eight years ago—this was discussed with the Department of Health, and the recommendations of the B.M.A. and everybody else associated with the staff side were that we should be paid roughly the same as the consultants were getting at that time. The consultants at that time, speaking from memory, were getting £2,750, and the B.M.A. on our behalf asked for £2,800, to give them room for manoeuvre with a view to coming down to about roughly the same figure.

4856. *Chairman:* This was before the 1954 settlement?—Yes, Sir. The position has not altered at all in Scotland. This claim was not recognised, we just did not get it. Then there was the Guillebaud report—there was first of all a report of March 1951, which the Secretary of State decided on advice not to publish. Then Guillebaud made his report and he said he thought there was a case for the Superintendents in Scotland being paid better salaries than they were getting. Nothing happened about that, and finally the Henderson report was published, and you have seen the recommendations. Fundamentally the position is that the recommendation as regards salaries in the Henderson report simply confirms what the B.M.A., the consultants and ourselves have always said in Scotland right from the beginning.

4857. *Sir Hugh Watson:* Can you give me the Guillebaud reference, Dr. Francis?—No, Sir, not offhand. I am talking from memory, but I think he makes a reference to recruitment.

4858. At all events, so far as the question of remuneration is concerned your point is that there have been these various recommendations, and arguments have been put forward in Whitley B, but this is the highest that your branch of the profession have so far been able to achieve?—Yes, Sir.

4859. I have just been given the reference to the passage in Guillebaud; it is paragraph 414: "We have had a considerable amount of evidence . . . from Scottish witnesses . . . indicating that it is becoming increasingly difficult to recruit men of the right calibre . . . and if it is found that the salaries of medical superintendents are inadequate to maintain proper recruitment they should be revised". Guillebaud of course was enquiring into the cost of the National Health Service as he found it, so this observation by Guillebaud is what my learned friend Sir David Hughes Parry would call obiter. But Guillebaud made the point.—Yes, he did, and our point is that the position is just the same as it was eight years ago.

4860. *Chairman*: And is it affecting recruitment?—Yes, I think so.

4861. Are you actually short of possible candidates to follow any of you?—Yes.

4862. *Sir Hugh Watson*: When the Commission is considering this question of recruitment, they want to consider it from two aspects: first, the question of quantity, and secondly the question of quality. How do you find the position in regard to both these aspects of the matter, both quantity and quality?—You mean as regards recruits?

4863. Yes, as regards recruits. Supposing you have a vacancy—I suppose you would start in your service by being a deputy Superintendent?—Yes, Sir.

4864. Supposing you want a deputy Superintendent for the Royal Infirmary—you advertise, do you?—Perhaps Dr. Bainbridge should answer this.—*Dr. Bainbridge*: In the Eastern region in Scotland we have had a series of advertisements for deputy Medical Superintendents. In Dundee in the General Hospital we have a Group Medical Superintendent who is responsible for the two teaching hospitals and certain ancillary hospitals, and he is supported by a deputy Group Superintendent. When I went there about three years ago, we lost the deputy Medical Superintendent, who went to one of the English Regional Hospital Boards. We advertised after that and we got one good person, a man who had a higher qualification in surgery. He was doing casualty surgery work in Newcastle region, he was interested in administration and he came to us. He was with us for only a year when he

went to the Northern Ireland Regional Hospital Board as an assistant medical officer. Within a year of being there he was appointed as a deputy with one of the Metropolitan Boards. Subsequently, as a result of two advertisements, we appointed a further person who had been a junior clinician in one of the Glasgow hospitals; he had been acting as deputy Superintendent under the good auspices of the Medical Superintendent in that particular hospital, and he is with us at the moment. It is quite apparent that there are people who are interested in administration, but there are very few coming forward. But there are some of very good calibre. I would quote certainly this person who moved from us to Northern Ireland and then to the Metropolitan Board. He is a person with an F.R.C.S., and with war experience, a man of probably about 40 years of age—I forget his age at the moment—and certainly of good calibre. But think it should be realised that the only promotion prospects for Medical Superintendents are within the Regional Hospital Boards, and of course these are limited. There are only 20 such senior posts throughout the whole of Great Britain so there are very few for them to go to. Certainly in Scotland it does appear to me that if we appoint a person as a deputy Superintendent we probably lose him to south of the Border or to Northern Ireland.

4865. That leads me on to another point. The Henderson Committee made certain recommendations with a view to broadening the base of your service and making it what they called a career grade. You of course have seen the Department of Health memorandum No. 58/45. I do not propose to go into it in detail, but that does put forward a scheme for an alteration and a broadening of the service. That would give you a wider field, would it not?—Yes, I think this will help. This of course has just recently been published; it has not been in front of our Association yet and we have not really had a chance to discuss this in detail, but I think this closer integration will prove beneficial.

4866. The thing is only dated 3rd June, so it is very recent.—*Dr. Francis*: We have not had the opportunity of discussing it with our Association, Sir, so anything we say on it would be entirely our personal view rather than that of our friends.

4867. I do not think the Commission really are concerned to go into whether it is a good thing or a bad thing, but it does open up a possibility of a wider field for persons with medical qualifications who are interested in hospital management?—There is one point I would like to make on this, Sir, if I might, and that is that it would appear that their idea is that having been Superintendent of a hospital you then seek your promotion up through the Regional Board. In Scotland there are only five Regional Boards, there are 14 in England, and there are a large number of Superintendents. Our feeling is that being a Superintendent of a general hospital, a big teaching hospital, is a worthwhile business in itself, not a means of promotion to somewhere else, that it is in fact the top of the tree. While this co-ordination of both Superintendents and Regional Boards into one service is a good thing in general, I do not think it is going to help the Superintendents very much if they have simply got to get jobs away from their own hospitals, which they have learnt to administer very well. There is a different type of mind needed to do the day to day administration, to take the quick and difficult decisions in a hospital, compared with work in a Regional Board.—*Dr. Bainbridge*: Perhaps I misled you slightly in my previous answer, and if I may clarify it, I was not implying that the Medical Superintendent should automatically seek promotion in a Regional Board appointment. When I said there were only 20 senior posts higher up for which they could apply, I really meant that the financial structure was such that an entrant, looking at the financial prospects of such an appointment, would see this and realise that that in all probability would be as high as he could go. There are so very few posts ahead, and the present salary structure really is a deterrent to a young person entering medical administration.

4868. I do not want to pursue this matter very much further, but what this memorandum says as its concluding point on the principles of reorganisation is: "The requisite status and influence of these medical posts will demand ability and personality in the holders; the calibre of the officers obtained will, in turn, depend upon the scope which the posts offer for exercising these qualities".

What you are saying just now is that when you become a Superintendent you have got as high as you can, you are really fulfilling your function and you feel you are doing a worthwhile job?—*Dr. Francis*: Yes, indeed, it is a very fine job.

4869. But the point about what is in this memorandum is that it is going to create the opportunity for people who are minded to go in for hospital administration, and have the ability and personality, to enter the service by means of a variety of routes. Thus you might get people coming in in the lower grades who would not be induced to come in at the moment?—Yes, Sir.

4870. *Dr. Francis*, let us go back to the Henderson Report. His report was that the amounts paid to the posts of greatest responsibility in medical administration should compare broadly with the salaries of consultants. What do you understand that phrase to mean—"should compare broadly"?—*Dr. Francis*: That is page 1040 of our memorandum to you, Sir, where entirely in the spirit of the Henderson Report we drew up what we thought fair proposals.

4871. I would like to know very much what you understand by the expression "compare broadly". We have been faced in another connection with the famous document you have no doubt read. In all his reports Spens enjoined those who came after him to have direct regard to the cost of living and the remuneration in other professions. What is the difference between having direct regard and comparing broadly?—*Dr. Beddard*: The answer of course is that *Dr. Francis* did not write the words.

4872. I know who wrote the words.—But I think the interpretation, certainly that I put on it when I read it, was that the salary should, as it were, bring the holder into the same sort of income bracket as the consultant. I think that at the moment all of us in medical administration both at Regional Boards and as Medical Superintendents of hospitals, feel we are one of the specialist staff. This point has already been made. Our speciality is administration. It means we have got to know the Acts and the Regulations to put it at its widest; we have to know how to present things to our Boards, we have to have all sorts of background knowledge,

the same way as the specialist has to have his background knowledge. We feel we are meeting on equal terms the specialists in different fields of medicine; we meet them and work with them, and this applies to the Regional Board medical staff as well as the Superintendents. We are in a rather lower income bracket and we felt the Henderson Report recognised the fact that the senior medical administrators in the Service were on comparable terms and status—and in this world of today that means salary—with the specialists in the hospitals.

4873. Do you consider whether the sort of people that the memorandum 58/45 contemplates will be properly remunerated under the scale—"Headquarters Medical Staff of Regional Hospital Boards" which was set out as Appendix P to the factual memorandum prepared by the Ministry? Do you have this document?—No, Sir.

4874. *Chairman*: You have seen it?—It is the Ministry's factual memorandum put out last June, and is chock full of unchallenged facts about the whole problem of medical remuneration.—*Dr. Francis*: I do not know if that has been circulated in Scotland, Sir. I have not seen it.

4875. *Sir Hugh Watson*: I do not want to appear to press you on this. Like you, I have not had the chance to discuss the Department of Health's memorandum with my colleagues and I find it very difficult to swallow, to put it crudely, the conception that even with his experience and his knowledge of Acts of Parliament, as Dr. Beddard put it, a Medical Superintendent can be compared with a consultant from the point of view of his attainments and his ability and the discipline through which he has gone. I cannot help feeling that that is why Whitley B has not been able to award any higher remuneration than they have done up to date; and I think it would help the Commission very much, Doctor, if you could tell us some reasons why it should be different. I do not know what Henderson meant when he said "compare broadly with the salaries paid to consultants".—If I could answer that in two parts, on the question of the differences in the training, there is no way of learning to be a Medical Superintendent at the present time apart from learning it as

an apprentice, and it would be a little hard to penalise us just because there is not a qualification we could take. The spirit is willing but there just is not the opportunity. I am quite convinced that the type of training and personality and the sort of work a Superintendent has to do is comparable without any doubt with the sort of work a consultant does, as regards the wellbeing of the community. It is an exacting job with a great deal of hard work and certain qualities.

I think when the Henderson Report said "posts of greatest responsibility among the Superintendents should be broadly comparable" we took that as being comparable to the basic consultant scale, rising to £3,250. We scaled things down from that so that the three top jobs in medical administration went up to just the present consultant's salary and the rest tapered down. We were not unrealistic enough to think the Superintendent of a small hospital should get the same as a consultant, but we thought the three top jobs should get a little less and the others scaled down as on page 1040 of our memorandum. It was a genuine attempt to interpret this in the spirit of the Henderson Report, which I would like to emphasise is exactly what has been said all along in Scotland, right from the start. It is a unanimous feeling of our own professional colleagues, both consultants and general practitioners, and of the B.M.A., that our top jobs ought to be paid at a rate roughly comparable to the consultant.

4876. *Dr. Francis*, you are aware that the proposals set out on page 1040 represent an increase of about 38 per cent. for the four highest groups and 33 per cent. for the two lowest groups?—Yes, Sir.

4877. Whereas what the B.M.A. are asking for is 29 per cent. on the remuneration existing before the 5 per cent. interim award was put into operation.—The position is very different from our point of view. It is not a cost of living increase based on the drop in value of the pound in the last so many years; it is to try to put right something we feel should have been put right eight years ago.

4878. Please do not imagine the Commission are prepared to agree to a request based purely on the cost of living.

—No, Sir, but we feel from the point of view of the 38 per cent. and these other percentages you mentioned—we did not look on it that way at all. The Henderson Report having vindicated most emphatically the views of the profession in Scotland during the last eight years, we thought it only right and proper, as you were having this Royal Commission, to put forward our own views on remuneration. We did not think of it from the point of view of the B.M.A. 29 per cent.; we just took what Henderson said, viewed it in the same spirit and did not put a piece on to bargain. We tried to look at it from the point of view of fair honest men. We discussed this throughout Scotland and took great care over the figures and we think they are exactly what Henderson had in mind.

4879 Dr. Francis, supposing the proposals on the Department of Health's memorandum 58/45 were to be brought into effect—you have not had a chance to look at Table P in the Ministry's factual memorandum yet—but would that sort of scale of remuneration appear to you to be appropriate? You have at the top the scales operated from 1st April, 1955, and they go up to £3,600. (Copy of factual memorandum passed to the witnesses).—It depends where the Superintendents came in on this scale because there is a top and a bottom to it. Obviously they could be fitted inside that scale with a top rate of £3,600. We have only asked for a top rate of £3,250. They could certainly be fitted in; but the question is, where?

4880. For instance a Senior Administrative Medical Officer for the South-Eastern Region of Scotland comes in at £2,650-£3,250.—If you take the three top jobs from the Superintendents point of view—Glasgow West, Glasgow Royal and Edinburgh Royal, they would come in under the scale of the Senior Administrative Medical Officer for the Region and the £3,250 would fit in very fairly there. If you draw a line where it shows the Bristol Region, £2,350, under Deputy Senior Administrative Medical Officers, that just about embraces our proposals on page 1040.

4881. Yes, it is not far away.—So my answer to your question is that provided we were fitted into that, it would be eminently satisfactory.

4882. Mr. Gunlake: Dr. Francis, I notice you say that in drawing up these scales the Association has accepted for the present the existing grading of hospitals. Do you mean that if there is to be a grading then you think the hospitals are reasonably graded at the moment, or do you feel there should not be a grading?—There should be a grading, Sir, but our feeling was that as we had a little problem—we are trying to get our claims listened to—we did not want to rock the boat too much by upsetting existing grading in hospitals. We thought we would have a better chance of acceptance with less excuse for people to argue. I think, without question the system of grading in hospitals is not at the present time a very good one. It does not, for example, take account of out-patient hospitals.

4883. Chairman: The system of grading is that shown in Appendix B of the Henderson Report?—Yes, it is really based on beds. It is possible to have an enormous out-patient department entailing a great deal of extra work and worry and problems. I think that if one was hoping for the ideal, which one never can, one would like the grading to include responsibility for these large out-patient departments; but we did not want to upset the boat too much.

4884 Mr. Gunlake: Would the question whether they were teaching hospitals or not come into your view?—It does anyhow because the Superintendents in Scotland get larger salaries with teaching responsibilities than in the same sized hospitals that have not; £200 a year is included in their salary.

4885. Sir Hugh Watson: The criteria on grading are set out on page 25 of the Henderson Report, where it is stated that the Committee took into account a number of factors, the number of specialist departments and so on. I do not think we are concerned to enquire into the matter of grading—that is a Departmental matter.—In actual fact, Sir, I think it is done largely by beds.

4886. You have made your position quite clear at any rate, Dr. Francis. You feel that up to now the remuneration attached to the post of hospital administrator is too low, that it has adversely affected recruiting into what you consider to be a valuable, indeed indispensable service. You point to the fact that the Henderson Committee recommended

that the amounts paid to posts of greatest responsibility in that Service should compare broadly with the salaries paid to consultants. You take it that could reasonably mean that the three top jobs be paid on the rate of the lowest consultant and you apply the grading downwards so far as the rest are concerned. These are your proposals for the future remuneration of the hospital administrator, assuming things go on as they are at present?—Yes, Sir. I think our point is, as salaries are at present, what we put forward on page 1040 of our report, grading up to £3,250, is realistic and fair. If in the future you decided consultants should have increased salaries, we would hope, *pro-rata*, we would move up with them.

4887. *Chairman*: Is medical administration always a whole-time job within the Service?—Yes, Sir, very much whole-time, the middle of the night as well.

4888. I realise that, but I mean, you cannot be a nine or eight-elevenths?—No, Sir.

4889. But do you include, for instance, a large number of cottage hospitals—taking the North Eastern Region where general practitioners are responsible and no payment is made to them for the work?—*Dr. Beddard*: Yes, Sir. The position in the North East of Scotland is rather different. There are a number of very small hospitals in very small groups and there we invite one of the general practitioners—and sometimes they change from year to year—to act as the Medical Superintendent. In fact it is really quite a different thing from what we have been talking about.

4890. You are not suggesting there should be any special payment? There is now no payment?—There is actually, Sir. It is a very small payment that can be made, up to £250 a year, I think it is, for a small group.

4891. The Henderson Report says no special payment is made.—In practice it is, Sir. But that is really quite a different situation. Again in Orkney and Shetland the Medical Officer of Health also does certain administrative duties on our behalf, but most of the important matters are dealt with at the Regional Board by myself and my assistant. We do all the planning in the hospital for the Board of Management.

4892. *Sir David Hughes Parry*: What about the residence? Is residence provided for the Superintendent?—*Dr. Francis*: Yes, Sir, and they pay a rent, but in not all instances. Where the Superintendent is in a group of several hospitals, for example, he may well be living independently of any of them; but in big teaching hospitals, he is usually on the premises. I have a house with a garden, for which I pay a rent.

4893. Who is the rent fixed by?—By the Treasury, as Crown property. In the old days the Superintendent was infinitely better off because he got his house free.

4894. *Sir Hugh Watson*: When the Royal Infirmary was a voluntary hospital?—Yes, and some men stayed or pre-1948 rates of pay rather than come in on the new basis, but I did not have the option. I was appointed afterwards. I was a deputy.

4895. *Chairman*: Some men stayed on pre-1948 rates of pay with free houses, because they thought that was more favourable than the new rates?—Yes. —*Dr. Bainbridge*: It is not an automatic thing though that a house goes with these posts. I think, where they exist, it is really a carry-over of the pre-1948 position.

4896. *Sir David Hughes Parry*: There is a double advantage; there is the house and the tax rebate?—*Dr. Francis*: No, they do not give us any Income Tax rebate on that at all. I have had experience of this because I was Deputy Superintendent and when my predecessor, who was on pre-nationalisation rates resigned, I got the job. While getting the house ready I stayed in my own house in Edinburgh and it was thoroughly unsatisfactory. You cannot do the job so well if you are living a distance from the hospital. But financially I was certainly better off. I actually had to pay a bigger rent for my house than I let my own house for, so I lost heavily. You get no Income Tax allowances for having to live on the job—I wish you did.

4897. *Sir Hugh Watson*: Your English colleagues make the point that they ought to be given some allowance for participating in the social life of the hospital community.—My private opinion is, if I got a reasonable salary, by which I mean comparable to the consultant, I would be perfectly prepared to entertain visitors to the hospital and so on. At the present time it is extremely difficult

on my salary to give the sort of hospitality that I have received at other hospitals. At a place like Edinburgh Royal you have scores of people dropping in and entertainment costs can be very heavy indeed.—*Dr. Beddard*: This also applies of course at Regional Boards where one has a lot of visitors and one wants to entertain; I take quite a lot home. But I do not think any of us would make a tremendous point about it. At the same time we get invited out to lunch when there is a Board meeting, and special visits, and we put one against the other. But it does occur and my wife makes certain references to the house-keeping budget and so on. But I would not like you to think that we take it at all seriously.—*Dr. Francis*: We would not make a serious issue of it if we were reasonably paid, but we are not.

4898. *Mr. Gunlake*: What would you say this expense amounts to?—I have cut it down. One year we had thirteen sets of people come to stay.

4899. Let me put it another way. In your sub-paragraph xxi you say the Medical Superintendent should have an entertainment allowance. It would help if you could suggest what kind of allowance you had in mind.—In the old days of course they did get this in teaching hospitals. Sometimes there was an actual allowance and sometimes they simply said—send the bill to us.

4900. *Chairman*: It varies from place to place?—Yes, a place like the Royal does attract people in particularly large numbers. I would not like to mislead you on this. I should think it should be something between £25 and £50 a year. If one were reasonably paid one would not raise the point at all but would be prepared to take it in one's stride.

4901. *Mr. Gunlake*: In sub-paragraph xx you say, *Dr. Francis*, that the Associa-

tion should be included in the machinery for discussions and negotiations. We briefly talked of Whitley B. Does that mean the Association has made an attempt to be involved in this machinery and has failed and, if so, can you tell us why it failed?—When it all started way back we had not a Medical Superintendents Society and then we formed ourselves into an Association. We hope that in the future we will be recognised as a negotiating body.

4902. Have you made any attempt to get recognition?—Yes, Sir.

4903. And so far it has not necessarily been refused?—No, Sir.

4904. *Chairman*: You said you were formerly the Scottish Branch of the United Kingdom Association. What are your relations with the rest of the United Kingdom now? You are not affiliated in any way?—No, we simply committed hari kari and formed an entirely new Association with a much bigger and more active membership. It is really alive now. Our relationship with our colleagues in England is one of friendly alliance and association, but nothing more formal. Their Chairman and Secretary usually attend our annual general meetings and we attend theirs but we are not linked up in any way.

4905. *Mr. Gunlake*: To quote the famous words, your relations with foreign powers continue to be friendly?—Very friendly, yes.

4906. *Chairman*: We have covered all the points you wish to refer to, *Dr. Francis*?—Yes, Sir.

4907. *Chairman*: I think we have understood your views. Thank you very much.—Thank you very much indeed, Sir.

(The witnesses withdrew)

**EVIDENCE SUBMITTED BY THE MEDICAL SUPERINTENDENTS' SOCIETY
TO THE ROYAL COMMISSION ON DOCTORS' AND DENTISTS'
REMUNERATION****General**

1. The Medical Superintendents' Society represents the interests of medical superintendents of hospitals, and their deputies, in England and Wales. All mental hospitals, and mental deficiency hospitals, have as their chief officer, medical superintendents who have statutory powers. The mental and mental deficiency hospitals account for approximately 45 per cent. of the hospital beds of the country. Many of the former municipal hospitals, both general and special, still have medical superintendents, so that there are over 50 per cent. of the hospital beds of the country for which medical superintendents are responsible. Yet the very existence of the medical superintendent or physician superintendent has been tacitly ignored by the Ministry of Health.

2. Most medical superintendents are consultants in their various specialties and remunerated as such. They are given a variety of titles of which the most common are physician superintendent, surgeon superintendent or medical director. Some have been graded as senior hospital medical officers. The Society knows of only two medical superintendents in England and Wales whose work is wholly administrative; all others combine clinical and administrative duties. The position in Scotland is somewhat different in as much as the chief officer in all types of hospital in Scotland is a medical superintendent who, however, does not usually have clinical duties, but the Scottish Association of Medical Administrators will be dealing with their own problems.

3. The duties and responsibilities of the medical superintendents have been set out in considerable detail in the Report of the Committee on the Internal Administration of Hospitals (Bradbeer Committee, 1954) and we would like to draw the attention of the Royal Commission to Paragraph 61 et seq. and Appendix B, subsection ii and iii of that report.

History of the Society

4. The Society was founded in 1886. Its members were the medical superintendents of the Metropolitan Poor Law Infirmaries. All the minutes of its meetings since its foundation have been preserved. Its interests were chiefly clinical in those days, but as the various administrative problems of large hospitals increased so they assumed greater importance in the Society's proceedings. Subsequently, medical superintendents of provincial poor law infirmaries were admitted to membership, and still later medical superintendents of mental hospitals and other special hospitals. In 1935, deputy medical superintendents were admitted for the first time. There are 250 ordinary and 97 honorary members in the Society. The Society is divided into Branches arranged on a geographical basis, so that members may more easily meet to discuss mutual interests and problems. In 1954 the Scottish Branch separated from the parent body and formed the basis of the recently formed Scottish Association of Medical Administrators. The Society has at different times in its history made representations to governmental bodies on various topics, including the Royal Commission on the Poor Laws and Relief of Distress in 1906. It has given evidence to the Bradbeer and other committees since 1948.

5. The Society submits with this document copies of its Constitution and List of Members for 1956-57. We would call attention to its Objects in Paragraph 3, particularly 3 (a) which states: "For mutual help in administrative problems, and in the promotion and maintenance of the highest possible efficiency of Hospitals." We are the only body specifically concerned with the interests of medical superintendents and their deputies.

Comments on various points raised by the Royal Commission in its circulated Memorandum.

6. Question (ii).

The quality of British qualified doctors is quite satisfactory. We are unable to comment upon the quantity in general, but have found that there is a consider-

able shortage of juniors offering themselves for service in certain specialties such as psychiatry and neuro-surgery, with the resulting failure to attract applicants of suitable quality. We believe that this is due to the poor prospects of promotion in such specialties. This is particularly true in the provinces.

7. Question (v).

The prospects of a newly qualified doctor are vitiated by the rigidity of the Health Service. A man cannot readily transfer from one specialty to another, nor into general practice. In general practice too he cannot readily transfer from one part of the country to another.

8. Question (vi).

In certain specialties there is a bottle-neck in promotion prospects, in consequence of which (as referred to under (ii)), there is a tendency to take up general medicine and obstetrics from which an easier transfer to general practice is possible. In time, this creates further congestion in these latter specialties.

9. Question (vii) (c and d). *Relative advantages and disadvantages of whole-time and part-time consultant practice.*

(a) *Advantages of whole-time consultant service.*

1. The divorce of financial consideration from clinical work.

2. The consultant is able to devote himself exclusively to his hospital work and domiciliary consultations. He is not exposed to a conflict in loyalties between hospital and private practice.

3. The working conditions of the whole-time and part-time consultant are essentially the same, as far as his hospital work is concerned, and there is no difference in security. The Society is definitely not in favour of a fully whole-time service, but believes that there is a place for both whole-time and part-time consultants. Indeed, a proper balance between the two gives a sounder and more healthy service.

4. In certain specialties in some areas it would not be possible to get suitable men other than whole-time consultants, as there would be little or no opportunities for private work, e.g. radio-therapy, thoracic and neuro-surgery.

(b) *Disadvantages of whole-time consultant service.*

1. The whole-time consultant must make eight free domiciliary visits each quarter before he becomes eligible for any fees.

2. He is not allowed expenses for income tax purposes which his part-time colleague is allowed, such as the cost of books and journals, subscriptions to professional societies, and the renewal of instruments and other equipment, etc.

3. His earnings are limited to his salary, plus certain specified fees, while the part-time consultant has no limit to his earnings outside the Hospital Service. The latter, if holding the maximum number of sessions, nine per week, is paid for nine and a half sessions work. His pension is also therefore relatively higher as far as his hospital work is concerned. Many whole-timers in consequence are electing to go on maximum part-time service because of the financial advantages. It might be as well at this point to refer to the Report of the Royal Commission on the Taxation of Profits and Income. In their report, in paragraph 129, the Royal Commission states that the general impression is that the rule governing the deduction of expenses in respect of offices or employment under Schedule E is too narrow. This is of course Rule 9. They recommended a re-wording of Rule 9 on less restricted lines allowing the deduction of all expenses reasonably incurred for the appropriate performance of the duties of the office or employment. They also made recommendations with regard to personal expenses, including such things as entertainment allowance, benefits in kind, and reimbursed expense.

4. It may be argued that the whole-time consultant, if working in the hospital only, may develop a parochial outlook, but this can equally apply to the part-time consultant, and is dependent upon the personality of the individual. It might equally well be argued that the part-time consultant, if attached to several hospitals, may have very little interest in the community life of any of the individual hospitals.

10. Question (vii).

(F) Senior Hospital Medical Officers.

No grade has given rise to more frustration than this one, and its future should be given careful consideration. It was originally designed for those who in 1948 were not considered worthy of consultant status, and was intended to be a grade which would die out. In spite of this, new appointments continue to be made to this grade in certain specialties; in fact the grade is being added to the establishments of certain hospitals. The Society disapproves of the grade as it is at present constituted, and considers that while it still exists individuals in it should have their grading reviewed at regular intervals of not more than five years.

11. Question (viii).

The salary of a junior hospital officer (i.e. below registrar grade) after registration should be raised to a level comparable to that of a trainee assistant in general practice. The conditions during the training years (25 to 35) are very unattractive and indeed cause considerable financial hardship and much frustration.

12. Question (xv).

Merit Awards.

Many people disapprove of merit awards, the chief objection being the secrecy with which they are surrounded. It is true that there are certain advantages in this very secrecy. The criteria on which they are awarded are not known, and we consider that certain standards should be laid down. We cannot offer any satisfactory alternative to the present system, because some such method of rewarding specific talents and skill is desirable. It might, however, be suggested that suitable representative regional committees should be officially appointed to advise regarding such awards.

13. At present only clinicians are eligible for merit awards.

We consider that those men who are pre-eminent in the administration of their hospital, quite apart from any clinical work they may do, should not be excluded from consideration. It is the total picture of the man's professional work in the service which should be taken into account.

14. Question (xx).

Whitley Council Machinery.

There is general dissatisfaction with the Whitley Councils.

The Gullebaud Committee Report discussed the matter in considerable detail (paragraphs 679 to 698, and 734). They were originally set up for those in government employment, and if the employee was dissatisfied he had the alternative of other work with another employer. In the National Health Service there is no alternative employer for the doctor. This is an entirely new feature in public service. We deplore the present wrangles concerning remuneration, and consider that they could be avoided in future if there was a proper system of independent arbitration at the request of either side.

15. *Remuneration of Medical Superintendents.*

The Society does not intend to express any specific views regarding the remuneration in general of consultants and other hospital medical staff, as evidence on this will be fully presented by the British Medical Association and other bodies. It is concerned with the remuneration of medical superintendents and their deputies in relation to that of exclusively clinical consultants. All mental hospitals have medical superintendents, and practically all sanatoria and special hospitals, except the very small ones. A large number of general hospitals also have medical superintendents. With the exceptions already mentioned in paragraph 2, all combine clinical duties with administration. In accordance with the Industrial Court Award of the 22nd January, 1952, if a medical superintendent is engaged for 32 hours per week in clinical duties he is paid wholly as a consultant or a senior hospital medical officer, according to his clinical grading.

16. In addition to his clinical work, the medical superintendent has administrative responsibilities and duties, and these may be at times of greater moment and of a more demanding nature in time and mental effort even than his clinical work. If resident he is never wholly off duty unless he goes out of the building: even then he may be held responsible for things which happen in the hospital when he is absent. In other words, he is more completely whole-time than any other medical officer.

17. In most cases it is a condition of his employment that he is resident (or must live so close to the hospital that he is virtually resident), the employing authority recognising the obvious value of having a senior officer upon the premises. This condition of residence imposes many disadvantages both on the medical superintendent and his wife and family, particularly in isolated areas. Many mental, mental deficiency and special hospitals are sited away from towns. As a result of this, social contact both for the medical superintendent and his family is not easy, and he is not able to purchase a house for a permanent residence. The charges made for his accommodation would go a long way toward meeting a redemption mortgage on a house that he might occupy if non-resident. When he approaches retirement, then, in the latter years of his life, he has to begin the process of purchasing and setting up a new home.

18. His administrative responsibilities do not end with the day-to-day administration of his hospital. He is expected to attend the regular hospital committees, and he alone is expected to attend a large number of special sub-committees. He also has to interview many of the other senior, lay, and nursing officers. He is expected, too, to take part in all the social activities of the hospital, a duty which his purely clinical colleagues may well escape. This is true in all hospitals and especially true in a mental hospital, where he must take the lead in many of the recreational activities of the patients. These many demands upon his time often result in his sacrificing not only his own social activities, but the very necessary attendance at medical societies and the taking part in similar professional activities. As a consequence also, the development of his clinical work to a degree which might earn him a merit award is liable to suffer.

19. It is no wonder, therefore, that there is a steadily increasing difficulty in finding suitable candidates for the post of medical superintendent. Both the Bradbeer Report (paragraph 118) and the Guillebaud Report (paragraph 414) refer to this point. The latter Report says in paragraph 414: "It should certainly be investigated and if it is found that the salaries of medical superintendents are inadequate to maintain proper recruitment they should be revised." Already quite a number of medical superintendents, because of these disadvantages, have given up their posts and taken a purely clinical post, either in their own or other hospitals. Equally undesirable is the possibility that some men may accept the post of medical superintendent in order to achieve consultant status, with the idea that in the future they may take a purely clinical consultant appointment.

20. For all these reasons the Society argues that a medical superintendent should be given extra remuneration over and above his purely clinical colleague. Only he has his finger on the pulse of all the hospital activities, and his value to a management committee which regularly seeks his opinion on different problems is immense.

21. Both the Bradbeer Report (paragraph 72) and the Guillebaud Report (page 146), agree that "the medical administrator must be a consultant in active clinical practice." With this we agree, with the proviso that medical superintendents whose administrative duties necessarily take more than two sessions should not be penalised. Some medical superintendents, however, have been graded as senior hospital medical officers. On the merit or demerit of this clinical grading in individual cases we cannot, of course, comment, but we do contend that, because of the many responsibilities he carries as an administrator, and because of the many disadvantages of the post he holds, a strong case can be argued in favour of giving these medical superintendents the grading of consultant in relation to his administrative duties.

22. Members of our own profession, among others, may raise objection to the suggestions contained in the last two paragraphs. Many consultants in the hospital service in England and Wales, though not in Scotland (see the report on Medical Superintendents and Medical Staff Committees issued by the Department of Health for Scotland in 1957), have been keenly critical of the post of medical superintendent. Guy's Hospital is a notable exception. They would, therefore, have opposed the suggestion that the medical superintendent should receive higher remuneration than a consultant, but it should be remembered that medical superintendents do not appoint themselves. They are appointed by employing authorities who have deemed the appointment necessary, and have been appointed in open competition.

Prior to 1948, the competition was very keen, with many first-class applicants for the post. It is particularly frustrating to those members of the profession who were appointed as medical superintendents prior to 1948, and who were then regarded as suitable men for the post and who have now been graded as an S.H.M.O., to find that others who were unsuccessful in their application for the same or similar posts, are now graded as consultants.

23. It may be asked why do we medical superintendents continue in our office, and why do some candidates still come forward. There are many reasons, but the chief one is that we believe that a hospital in which there is a medical superintendent will function more efficiently and more economically. Being a doctor, the medical superintendent's chief care is the welfare of the patient, and it is his constant concern that all the various departments of the hospital function efficiently to that end.

24. *Deputy Medical Superintendents.*

We do not approve the suggestion contained in the Bradbeer Report (paragraph 81), that the deputy should be of R.M.O. or R.S.O. status. In this we are supported by the Central Consultants and Specialists Committee, which in its comments on the Bradbeer Report stated that the deputy medical superintendent should be a consultant. Some hospitals now-a-days have no deputy medical superintendent, a fact we deplore. We consider such an appointment is necessary, and entirely agree that his status should be that of a consultant. We contend also that in order to induce men to take on the duties of the deputy, he must be given extra remuneration, which should be not less than 80 per cent. of that given to a medical superintendent.

References :

1. Report of the Committee on the Internal Administration of Hospitals. (Bradbeer Report, 1954.)
2. Report of the Committee of Enquiry into the Cost of the National Health Service. (Guillebaud Report, 1956.)
3. Medical Superintendents' Medical Staff Committees (Scotland), 1957.

Examination of Witnesses

DR. G. MCCOULL, *President of the Society*

DR. M. J. BROOKES, *Chairman of Council*

DR. V. COTTON-CORNWALL

DR. A. SKENE

DR. J. M. MILLOY, *Honorary Secretary*

on behalf of the Medical Superintendents' Society

Called and Examined

4908. *Chairman*: Dr. McCoull, you will be speaking mainly for the Society, will you, or will you all wish to give evidence with yourself acting as the leader?—I think that is the position, Sir, yes.

4909. It is for anyone you wish to answer any of the questions we may put to you and in your turn, of course, you will be asked questions from any member of the Commission, particularly from Sir Hugh Watson who has been Chairman of the particular sub-committee that has gone through your evidence and has marshalled the questions we propose to put to you. Would you please remember, first of all, that anything you say will be reported?—*Dr. McCoull*: Yes, Sir.

4910. We will question you fairly thoroughly on a few aspects of this very specialised subject within our whole subject because if we do not there is nobody else to do so. Do not think we are being hostile in so doing: equally do not take it we are accepting without any comments any points that we do not raise because we have gone into many of them sufficiently with other bodies. Would you start by telling us the scope and membership of the Society including perhaps a description of the different types of membership and of activity as represented, for instance, by the five of you who are here today?—Could I just introduce the people who are here? Dr. Brookes is a consultant psychiatrist and in charge at the Shelton Hospital, near Shrewsbury; Mr. Milloy is consulting surgeon and in charge at St. Mary Abbots Hospital Kensington; Dr. Cotton-Cornwall is chest physician and is deputy superintendent at the Aintree Hospital, Liverpool and Dr. Skene is consultant physician in charge at the Walton Hospital, also Liverpool. I myself am in charge at the

Prudhoe and Monkton Hospital, which is a mental deficiency hospital. We are all consultants.

4911. How many members have you?—250 in our Society, Sir.

4912. How many could you have had if everybody eligible were what the Scots call a paid up member?—We have tried to reckon that out this morning and thought somewhere about 400, Sir. We cannot get exact figures.

4913. You are all consultants. How many of the 400 would be of consultant status?—We do not know, Sir: it must be 95 per cent. Could I say at this point that Dr. Skene has got some figures just this morning from the Ministry. We said in paragraph 1 of our memorandum that the mental and the mental deficiency hospitals account for approximately 45 per cent. of the hospital beds of the country. We said that for over 50 per cent. of the hospital beds in the country medical superintendents are responsible. We think that is modest, Sir. We were not quite certain about figures. We thought we were under-stating. Dr. Skene has some further figures.

4914. Would you like to give us those now, Dr. Skene?—*Dr. Skene*: We only have the figures in respect of eleven of the fourteen hospital regions in England, but these show that there are 368,600 beds in these eleven regions and of these 221,600 are in hospitals which are administered by medical superintendents by name or by other terms such as medical director, physician superintendent and so on, which is just a fraction over 60 per cent.

4915. Those were mental and mental deficiency hospitals?—No, Mr. Chairman, all hospitals in England and Wales with the exception of three regions—Oxford, North East Metropolitan and Birmingham—where we have not been able to get the figures.

4916. *Sir Hugh Watson*: Yet, you say, the very existence of the medical superintendent has been tacitly ignored by the Ministry of Health. What does that mean, Dr. McCoull?—*Dr. McCoull*: It means that in regard to circulars, memoranda and other documents from the Ministry the set up is such that they come down through lay hands and very often we find that the medical superintendent as the head of the hospital is simply not named. They go direct to the lay side. Very often we do not see them.

4917. He is by-passed?—We are often.

4918. *Chairman*: You are often by-passed on subjects dealing with administration?—Yes, Sir. Could I say that there is an official publication, the Hospital Directory I think it is called, where no medical superintendent is put down at all. Quite apart from being in charge of the hospital his name just does not appear under any hospital in the country. That is published by the Ministry I am told, Sir.

4919. Have you ever brought this to the attention of the Ministry?—As a body we have not.—*Dr. Brookes*: I think we did send a communication about five years ago.

4920. What was the answer?—I cannot remember now, Sir.

4921. *Sir Hugh Watson*: Did you employ what in other circumstances is called a follow up? You did not return to the charge?—*Dr. McCoull*: No.

4922. It astonishes me because as you know the medical superintendent is recognised as a grade for remuneration.—Are you speaking of the administrative superintendent?

4923. I am reading from the factual memorandum given to us by the Minister of Health. Will you look at page 79, Dr. McCoull? You will find medical superintendents, graded as consultants, who are normally engaged for at least 32 hours per week are remunerated as if the whole of their duties were clinical. That seems to recognise the existence of medical superintendents.—Yes, Sir.

4924. Or again in the next paragraph, even more so, the salaries of whole-time medical superintendents are related to a pointing system.—I think you have left out the important words "engaged wholly in administrative duties."

4925. I beg your pardon. My point is this: the document seems to recognise the existence of medical superintendents.—Indeed, I think it does. It recognises here the wholly administrative medical superintendents of which we have not got a representative. They are very few indeed, Sir.

4926. But also paragraph 1, Dr. McCoull, recognises medical superintendents graded as consultants?—Yes, Sir. If you are making the point we are recognised the answer is yes, Sir.—*Dr. Skene*: May I just say that we are recognised as consultants just as all the other consultants. In this document, as we exist and have to be paid naturally I presume we are recognised for purposes of payment, but for purposes of administration in the general hospitals—I specifically say general hospitals—there is no doubt there is considerable substance in what has been said by Dr. McCoull.

4927. *Chairman*: What I cannot understand is why, if you are being by-passed on things on which you ought to be consulted or at least informed, the Society has not said so with greater force?—*Dr. McCoull*: It is a very small body, Sir.

4928. *Chairman*: I see.—*Dr. Brookes*: We have called the attention of the Ministry on several occasions to quite a number of instances in which we have been by-passed. We have had no replies.

4929. *Sir Hugh Watson*: Of course various bodies have expressed views about this matter. The Guillebaud Report did confirm the views of the Bradbeer Committee that the medical administrator must be a consultant in active clinical practice. I think as the Chairman says this is a matter for yourselves. It is not a matter for this Royal Commission. It seems unfortunate. This Commission is concerned with remuneration you see. Could you tell us, Dr. McCoull, how many of your members are superintendents of mental hospitals?—*Dr. McCoull*: Not exactly. I should have thought about 90 per cent.

4930. Of mental deficiency hospitals?—I included mental deficiency in that 90.

4931. Of infectious diseases hospitals?—A small proportion.

4932. General hospitals?—Seven or eight per cent. That is round about the distribution.

4933. You mention in your memorandum that there are only two hospitals in England and Wales where there are medical superintendents whose work is wholly administrative.—Only two we know who are members of our Society. We do not know of any more.

4934. Can you tell us what proportion of the medical superintendents to whom you refer are consultants on the one hand and S.H.M.Os, on the other?—We tried to think that out this morning. The number of S.H.M.Os, is very small indeed. It cannot be more, I imagine, than a dozen in the whole country.

4935. Tell me, Dr. McCoull, would you accept the definition of the duties and responsibilities of medical superintendents as laid down in the Bradbeer Committee's Report? You have probably seen that?—Yes, I have seen it, Sir. In general I would say yes, Sir. I would say in the mental and mental deficiency hospitals there is something extra but in general I think we can accept the Bradbeer Committee's Report.—*Dr. Skene*: May I ask Sir Hugh Watson whether he is referring to Appendix B or paragraph 61 of the Report because paragraph 61 enumerates a number of duties which the Report takes to come within the content of medical administration, whereas the Appendix, of course enumerates duties laid down for a medical superintendent. It may appear there is a very fine line of difference between those two items, but of course medical administration is carried out in the same sort of way in hospitals which do not have an appointed medical administrator.

4936. I think that is the point. Subject to that, with that comment, Dr. Skene, you would accept the outline of the duties and responsibilities of a medical administrator as set out in paragraph 61 of the Bradbeer Report?—Yes, Sir.

4937. You point to Sections (ii) and (iii) of Appendix B as illustrating the duties which have been laid down by a certain Board for a surgeon superintendent, and a memorandum on the relationship of medical superintendents to specialists on hospital staffs?—That is so.—*Dr. Brookes*: Those duties, Sir, are in relation generally to non-teaching hospitals,

to mental and mental deficiency hospitals, where the appointment of a medical administrator is specially set down in Statutory Instruments.

4938. Mental hospitals are by statute obliged to have a medical superintendent?—And mental deficiency hospitals. Statutory Instrument 419 lays down that he is the chief officer.

4939. As I said, this Commission is concerned particularly with remuneration. We are obliged for the comments you make in paragraphs 5 to 13 of your memorandum. Perhaps you will excuse my not dealing with them. We have had evidence from a considerable number of bodies and think we know the position about them.—*Dr. Cotton-Cornwall*: Might we, Sir, say something about some of the evidence that has been given on merit awards if you are not going to ask us any questions on that matter, because we do feel some of the statements made to you about the lack of interest shown by consultants in general in the merit award system does not correspond with the facts. Naturally everybody is interested in the amount of money that he receives and the fact that meetings in the regions have not been well attended is not due to the fact that people are not interested.

4940. *Chairman*: What is it due to?—If I may be quite frank, it is due to the fact that the question of merit awards is not dealt with at those meetings. People ask questions and they do not get answers. Since that has happened on several occasions people have ceased to attend. Speaking for the Liverpool region, the attendances at the beginning were very much better than they are now. If I may speak personally I myself went to the first two meetings that were held and decided it was a complete waste of time going to any more. I think that is fairly general—that feeling is fairly general.—*Dr. Brookes*: There are other factors. Sometimes the meeting is held at a distance from one's place of work—some 30 or 40 miles away, and it is held in the afternoon. One hardly feels inclined to go to attend a meeting at that time.

4941. I think we appreciate these meetings are held in fairly widely separated places at intervals and one cannot expect a very large attendance. In the past 250 people turned up in Newcastle.—There

have been good attendances in my area.
—*Dr. McCoull*: In paragraph 13 on merit awards, we say:

"It is the total picture of the man's professional work in the service which should be taken into account."

I feel that here we should point out to you that in the system of allocating merit awards to people it is laid down that administration does not count. In other words, one's success or otherwise in running a hospital community is not taken into account at all. We think that is part of a man's total professional capacity and we think it should be taken into account. We protest very strongly against the leaving out of administration from the merit award system.

4942. You know, *Dr. McCoull*, other bodies have raised the question of altering the line of demarcation of merit awards, bringing in types of doctor for instance who would not now be eligible. The Medical Research Council indeed raised that. There has been a generally expressed feeling it is best to leave the line of demarcation where it is. You knew that?—We know that this is for you to decide but we are protesting against the fact that administration does not count. They are the words that have been used. We think it is important.—*Dr. Skene*: I think we take that view because we feel that the duty of the medical administrator in the hospital service is an important one and for the good of the service. Consequently any condition of service which will make an important appointment of that sort less attractive will carry with it a handicap from the point of view of the recipient's future financial prospects and is not calculated to maintain the quality of the service in which we are interested.

4943. You are making the same sort of point at a different sphere to the one which has been made, for instance, by the Medical Research Council?—Precisely, *Mr. Chairman*.

4944. *Sir Hugh Watson*: There is this difference, *Dr. Skene*, if I may act as your advocate for the moment, that the people about whom you are talking are already consultants?—That is so.

4945. It has been expressed to the Commission that people who do no clinical work at all ought to be considered for merit awards. The Commission have so

far not been impressed by that argument. I am not saying they have decided anything, but once you get outside the realm of clinical medicine for which merit awards were primarily intended, you are in a very difficult and wide area: but your point is perhaps narrower—with respect, *Mr. Chairman*—because you are a consultant to begin with.—The point I am making, *Mr. Chairman*, is that the physician superintendent is a handicapped consultant in relation to his fellow consultants because there is a limit to that which even the most conscientious person can put into 24 hours and if he is undertaking clinical duties for nine-elevenths of his time he is expected to carry out clinical duties for nine-elevenths of his time. Bearing in mind that the Ministry three years ago stated that a particular consultant's task may be done in whole time or in nine sessions, at the option of the consultant, then obviously the man who is doing a nine session consultant post plus all his administration is extremely handicapped in undertaking any research work in which he may be interested as compared with the pure clinician. Consequently it is unjust for him not to be considered for a merit award.

4946. *Chairman*: *Dr. Skene*, paragraph 1 of Appendix F of the factual memorandum to which *Sir Hugh* referred earlier, says that medical superintendents graded as consultants who are engaged at least 32 hours a week in clinical work are remunerated as if the whole of their duties were clinical. Would that also apply for merit award purposes, to your knowledge?—I do not know: I presume it would.—*Dr. McCoull*: Yes.

4947. So that anybody who is engaged for 32 hours a week on clinical duties as a medical superintendent is eligible for a merit award?—*Dr. Skene*: Yes.

4948. To the full extent, and presumably if engaged for, say, 20 hours instead of 32, is eligible for the appropriate proportion of the award?—*Dr. Cotton-Cornwall*: There are people who are medical superintendents who have merit awards. We would not like to give the impression there are not any. The argument is it is more difficult for a medical administrator being either physician superintendent or deputy to obtain a merit award because he has not got the same amount of time to give to clinical research and writing and reading of

papers that the pure clinician has. I think that is the point I am trying to bring out.

4949. I think the Commission has got the point. I do not know to what extent they are convinced about its validity. We may need to ascertain more on that particular point from Lord Moran. I do not think that point has been put to us in that way before, that medical superintendents alone have insufficient time to do research work to keep to the level of other consultants. That is your point?—*Dr. McCoull*: They have not as much time.—*Dr. Skene*: May I put it this way? In the time the consultant has over and above his, if you like, routine work, the medical superintendent is very frequently undertaking administrative work rather than that more specialised type of work which is regarded I would say as more likely to make him eligible for a merit award.—*Dr. McCoull*: We could elaborate on that by letter if there is any doubt about it.

Chairman: I think the Commission has the point.

4950. *Sir Hugh Watson*: Of course as you know the Bradbeer Committee recommended that consultants engaged in clinical work who worked for part of their time in administration should not be prejudiced in remuneration by the fact it did so occupy their time.—*Dr. Skene*: Precisely. That is understood, Mr. Chairman.

4951. *Dr. McCoull*, in Appendix C to the Bradbeer Report there is a table which shows that throughout England and Wales there appear to be 129 medical superintendents for a certain number of hospitals?—Yes, Sir.

4952. Are these all the gentlemen who act as medical superintendents broadly speaking of hospitals?—*Dr. McCoull*: No, I said we think there are about 400 in the country. These figures have been very difficult to get and even now we are not too certain to about half a dozen of the exact number.—*Dr. Brookes*: May I say there is a very important footnote to that table which explains it.—*Dr. McCoull*: Page 16 of the factual memorandum gives the number of medical superintendents and deputy medical superintendents in England and Wales at 77, Sir. It is extremely difficult following these figures. Every time we see a new table we get a new figure. We think there are 400 in the country.—*Dr. Skene*:

We have confirmation from the Regional Hospital Boards of 11 regions that in these 11 regions there are at least 315 actually in post at work.

4953. *Chairman*: Why is there this uncertainty? Is it because they are treated as consultants in medical practice, because they are doing 32 hours or more a week?—*Dr. McCoull*: We think, Sir, it is because of the nomenclature. Sometimes a man is termed a surgeon superintendent, sometimes a physician superintendent and sometimes a medical director.—*Dr. Brookes*: That is explained in Appendix C of the Bradbeer Report where they say the amount of medical administrative work is much greater. A number of consultants, not classed as medical superintendents in fact devote a considerable amount of their time to administrative duties.

4954. That still does not necessarily affect this question of the number of medical superintendents. I should have thought this was something the Society would have wished to get right in the statistics of the Ministry?—*Dr. McCoull*: We have been trying to do that and have got it out of 11 regions. Three have not replied. We are certain of figures on 11 regions.

4955. Could I ask you to look at this Appendix C of Bradbeer under the heading of "Mental" and "Mental Deficiency", in which it would appear there are in total 44 medical superintendents. In view of the statutory obligation to have a medical superintendent in such hospitals, I should have thought there would have been far more.—These must be far more than that.

4956. There are 130 mental hospitals included in the table.—*Dr. Brookes*: The average number of big mental deficiency hospitals in each region is four; smaller places which have to have a medical superintendent, three. The figure is wrong, Sir.—*Dr. Skene*: May I just say, Mr. Chairman, that the official documents do lend some point to the comment we made in the first paragraph of our memorandum, that the existence of only 77 of us has been recognised in this official document, but we are 400.

4957. *Dr. McCoull*, this Ministry's Factual Memorandum came out as far as I can remember in July, 1957—it might possibly have been August. There should have been enough time to estab-

lish the true facts since then.—Mr. Chairman, we started to collect these figures in October.

4958. *Sir Hugh Watson*: I have forgotten how we got on to this. We were talking about merit awards. In your paragraph dealing with merit awards you suggest the setting up of representative regional committees. Could you just tell us a little about the ideas which prompt you to make that suggestion, following on what Dr. Cotton-Cornwall said about the Lord Moran meetings?—*Dr. McCoull*: Can I go back to what I know Lord Moran said quite a lot about to you, that is the Newcastle meetings and set-up there. He devoted a considerable time to that. I was in that group and know of it. Lord Moran comes once a year: a meeting is called for consultants and the meetings as a whole have been very well attended. I think 250 were at the first meeting. The figure has dropped possibly since. Even at a meeting held on Sunday night there were over 100 there. From that meeting in the Newcastle area was appointed a man to go on to a team of four which looks into the case of every consultant in that area and makes recommendations. Middlesbrough, Darlington and Sunderland I think each have similar committees. They go into each case in their own area. It is those committees we think ought to have some official recognition. They ought to be officially known as the recommending body. As it is you see from Lord Moran's evidence, those committees do not report to Lord Moran. They report to a Committee of the Regional Hospital Board, and say what they think to them. Finally Lord Moran meets the Regional Hospital Committee; who else is met nobody knows. I think he said in his evidence he asked individuals what they thought. No one knows who the individuals are—we have a very good idea—no one officially knows who they are, as between small committees who really are representative of the consultants, as between individuals and Lord Moran, and the Regional Hospital Committee he has co-opted. Then a list comes out which you do not see until the next meeting. We think there should be some official small body elected or appointed by the doctors and having some official recognition in this matter.

4959. *Chairman*: Dr. McCoull, it has been suggested and fairly strongly sup-

ported by many people in your profession, that the comparatively informal nature of ascertaining the real merits of particular people in these districts works better than a formal official committee system. You feel that is not so?

Sir Hugh Watson: To supplement what the Chairman said Lord Moran described the machinery to us very much as you have described it. He said at the end of the day all the indications pointed the same way; they all pointed to the same people.—I believe that to be true, Sir. I think the whole thing is that if a small committee puts up certain recommendations, places a man very high indeed, and then goes to the regional committee which also places the man very highly indeed and that man does not get a merit award but someone else does, then we think some official recognition of these committees should help that position.

4960. May I take it you are talking principally at the moment, Dr. McCoull, about the C awards?—I am talking about all awards.

4961. Because Lord Moran put it to us there was never any doubt about the A's.—I entirely agree: there is no doubt about the A's.

4962. There was perhaps some doubt but not a great deal about the B's.—Yes. It is largely the C's—the picking of a new man for an award, that is the difficulty.

4963. It was getting the man on to the ladder for the first time?—Yes, that is the difficulty, Sir.

4964. *Chairman*: Is this partly connected, Dr. McCoull, with the feeling that in the particular sphere of mental health there has not been as much recognition as in some of the other major spheres?—That has not come into my mind, but I have figures which I understand you have. The Royal Medico-Psychological Association have put up the figures that have been obtained about psychiatrists. No, I was not talking about that at this moment.

4965. I would like to know whether you think under this system, things have worked out fairly well or not. What do you think?—I think it works out as well as it can do under the system.

4966. Dr. Skene, is that your feeling?—*Dr. Skene*: I am not very closely acquainted with the system in the Liver-

pool region, because of course, the system appears to be different in each region; but I know there is established in the Liverpool region a committee to advise Lord Moran.

4967. Yes. My question was, do you think the results are very wrong in fact as far as you know?—I think allowing for human fallibility the results are reasonably satisfactory.—*Dr. Cotton-Cornwall*: That is not quite correct. I have a little more intimate knowledge of what is done. The committee you refer to is entirely an informal committee which advises the person Lord Moran consults in the Liverpool region, and the committee as such is not recognised by Lord Moran. I feel, Sir, the point we are trying to make is that although the end result may be very similar to what the end result would be if you had an elected committee making recommendations, that people would feel they were being more fairly treated. "X" and "Y" possibly "Z", are consulted; we do not know quite who is consulted, but it depends very largely on his opinion as to who in this region will get a merit award.

4968. I am talking now about the C merit award. I agree with what has been said about A and B. The difficulty does not arise there.—*Dr. Brookes*: I think, Sir, within my region people are tolerably satisfied. The only point I would make is the very low percentage of awards given to people in mental health.—*Mr. Milloy*: In my region we do not know much about it. I am surprised to hear from the other regions about these regular meetings. Only one meeting has been held in the London area which was when the first distribution of merit awards occurred. They met there and divided up A and B but wanted ten more C's. A small sub-committee of three was set up to recommend these ten. I happened to be a member of that sub-committee. It only met once and has not met again.

Sir Hugh Watson: I think Lord Moran did say he had a different method of dealing with London than the provinces.

4969. *Chairman*: Lord Moran gave a full account of his methods in the verbatim evidence which has been published by the Commission.*

* Royal Commission on Doctors' and Dentists' Remuneration Minutes of Evidence Days 3-4.

Sir Hugh Watson: Could you perhaps in a few words expound to the Commission your general view regarding the place of medical administration in general and mental hospitals?—*Dr. McCoull*: I can really only speak with authority on perhaps the mental and certainly the mental deficiency side. One of the other witnesses might do so as regards general hospitals. I do not think there is any doubt about it that medical administration in the mental and mental deficiency hospital is an absolute necessity. I do not think any other system—shall we say the system as used in most general hospitals now—will work. It will not work because the mental and mental deficiency hospital is a place—a community—where we, the medical superintendent and his staff, have to look after the whole life and living situation of the patient, where everything done inside that hospital has a reaction upon the life of the patient. That is certainly true in mental deficiency. I do not know how far it may be untrue as far as mental hospitals are concerned but I believe the position is the same. There is no way of looking after a person's total life—24 hours a day, perhaps for years, perhaps for a shorter time—than by medical administration. When I say medical administration I mean an administration that has a doctor acknowledged as the head. I leave out the words "medical superintendent"—a doctor.

4970. That means the doctor supervises if he does not deal with the detail of the whole administration of the hospital?—I think the better the doctor the less he does of detail, Sir.—*Dr. Brookes*: I think it is perfectly true of mental hospitals too, but he correlates other duties of the hospital. He acts as liaison officer.

4971. Does that apply to general hospitals also?—*Dr. McCoull*: Mr. Milloy and Dr. Skene can speak for general hospitals.—*Dr. Skene*: If I may, Mr. Chairman, I will say that the position is obviously in practice different in general hospitals in England today, but we have taken the view that the employment of a medical superintendent in a general hospital is highly desirable because the basic fact is that the hospital is simply a building to enable sick members of the public to be treated by doctors. And it seems reasonable that the administration of such an organisation

tion might well be carried on by a medical man.

In the Henderson Report on medical superintendents in Scotland, they said that they considered the employment of medical administrators in hospital was desirable and one of the arguments for the employment of these people was based on the part he can play in fostering the integration of the hospital service with other branches of the Health Service. I think that is a particularly strong reason for having one medical man recognised as an administrator, particularly in a large hospital and particularly in urban districts where there are large hospitals and where hospitals tend to become isolated units unless there is a discriminating medical man who continuously undertakes these responsibilities among others.

4972. I think I am right in saying in England the majority of general hospitals do not have whole-time medical superintendents?—*Dr. McCoull*: That is so, Sir.

4973. They have consultants who are part-time?—No, Sir, they have lay secretaries.

4974. Yes. They also have consultants who are part-time medical superintendents, although you call them physician superintendents or medical directors?—No. The average general hospital has as its chief officer a layman who is the group secretary and he is in charge of that hospital.

4975. *Chairman*: There is very often a lay secretary as well who is subordinate to the group secretary?—Subordinate to the group secretary.

4976. I think you said earlier that of your 400 possible members only about 7 or 8 per cent, that is to say 25 or 30 people together, would be in general hospital?—I would like to appeal to our secretary to make sure that is right.—*Dr. Brookes*. I think that figure is rather small; there are more than that—certainly more in the London area.—*Dr. McCoull*: Dr. Skene has the figure. *Dr. Skene*: I have not the figure of members of the society but have the figure in respect of hospitals other than mental and mental deficiency hospitals in the eleven Regional Board areas to which I have referred. It is this, that there are 184 medical directors, superintendents and physician superintendents of general and special hospitals.

4977. How many in mental and mental deficiency?—131. There are 315 superintendents altogether. But whereas the 131 mental and mental deficiency medical superintendents administer 162,000 beds, in the 184 other hospitals medical superintendents administer only 50,000 beds, that is to say, all the mental beds have a medical superintendent under statute. Only 60,000 out of the total number of general beds, which is 250,000, have medical administrators—60,000 out of 250,000.

4978. This rather modifies the figures you gave earlier about 90 to 95 per cent.—*Dr. McCoull*: It does; I said I was making an estimate.—*Dr. Skene*: Unfortunately we have had some considerable difficulty getting these figures and the last figures I received from the Ministry of Health only on our way here at 2 p.m.

4979. *Sir Hugh Watson*: Can you tell us the importance of the legal responsibilities relating to the freedom or custody of the patient borne by the medical superintendent?—*Dr. McCoull*: In the mental hospitals that is a very great responsibility. It has to do with the freedom of the subject, whether a person is just going to be kept in the mental or mental deficiency hospital or not. *Dr. Brookes* can speak better of the mental hospital: I speak as to the mental deficiency hospital. The work has been tremendous. New legislation has placed very increased responsibility on us, in spite of the fact that our legal responsibility is now largely being lightened by new regulations. A mental deficiency patient coming into hospital had to be certified at the end of the year; he was certified on admission and re-certified at the end of a year, then at the end of five years; that is going on all the time. Now we are taking in patients where this re-certification will not be necessary, but early experience shows that the responsibility of taking in mental defectives in an uncertified condition is certainly going to be much greater than before. There is no doubt of the responsibility—I am not talking of rights or wrongs—this informality is going to put on the doctor a very much increased responsibility. We are not objecting to it. It has ceased to be legally our responsibility.

4980. *Chairman*: Could I ask, Dr. McCoull, whether in the ordinary mental deficiency hospital this responsibility invariably comes directly on to the medical

superintendent, or whether it is simply he has the ultimate responsibility but doctors under him in fact take the decision in most cases?—I speak of a hospital where I am the only consultant. In my hospital the other doctors take their share of responsibility, but in questions of doubt I am the person who has to decide. I am the person they come to. If necessary I am the person who says what we will do.—*Dr. Brookes*: There are additional duties—safeguarding of the patient while in hospital.

4981. *Sir Hugh Watson*: Is it possible to say approximately how much time is involved in clinical work and how much in administrative work?—*Dr. McCoull*: This is all bound up in this question I found so difficult to interpret in reading the evidence given to you. Everyone will speak as though doctors work a 38½ hours week. As medical superintendent I can double that almost every week. I would say that the actual administration as administration does not take very much time. There are other people who do this work—the group secretary, the group engineer, they see to all these things. There is other work which is looked upon by some people as administration but in our opinion is purely medical. I had anticipated this question. On Saturday having had a busy day I started writing about 5.30 and finished after 10. I wondered if I would get this question and wrote down exactly what I had been doing. I can put it in to you. It is just a list of about 40 items as they occurred—the letters I dictated and the various actions I took. Looking over that I am quite certain that had to be done by a doctor and it is administration. You are not touching a patient; I did not see a patient during all that time. It is difficult to say how much the proportion of clinical time is when you do not know the total to start with and do not know what the administrative part is. You do not see a patient, nor do you order coal or flour or anything of that kind. I certainly do not.

4982. You were dealing with medical administration?—Entirely. If you are interested in the question I have got it somewhere written out.

4983. *Chairman*: If you would like to send us that for our private guidance, the Commission would be glad to have it.—Yes, Sir, I will send it on later.

4984. We have the point. You are dealing entirely with medical administration, not with lay administration nor with the actual clinical job of seeing patients.—I hope it is understood. I was asked to give a proportion of time but with so many unknowns I cannot give a definite proportion.

4985. *Sir Hugh Watson*: How far is the medical superintendent responsible for the clinical work of other consultants of the staff?—I would say not at all. I think as a medical superintendent he has got to see that outside consultants turn up for clinics, that they come in on time and do not keep nurses waiting all the day. I would say he has got to be responsible for seeing that the consultant is fully looked after, has the equipment he needs and is supplied with all his wants. I think for the part-timers the medical superintendent has got to see their treatment is properly carried out, that the nurses are doing their job, and so on, but as far as clinical responsibility is concerned I do not think the medical superintendent has any responsibility whatever.

4986. *Dr. McCoull*, in your paragraph 10 (f) I think you suggested that the Senior Hospital Medical Officer grade might be abolished. What do you suggest for its replacement?—It may be others may want to speak here, too, Sir. I think largely we think there ought to be a broadening out of the consultant grade. We do not think that some form of junior or assistant consultant is the right answer. Perhaps *Dr. Skene* has got views on that.

4987. *Chairman*: I would like to be clear on your own answer first. You say a broadening out; you do not want a junior consultant or assistant consultant. Do you mean simply an addition to the number of consultants? Is that what broadening out means?—I do not mean an addition to the number of consultants. I mean a broadening out of the salary scale so that a man will have a longer term to go and perhaps start earlier—a broader remuneration term, not more consultants.

4988. But the present Senior Hospital Medical Officers for instance, in terms of your answer would be consultants, but within a much broader salary range. Is that right?—*Dr. Cotton-Cornwall*: No, Sir. We have not said the present

Senior Hospital Medical Officer should be a consultant. We think the grade should die out as such and in name, but we think those left in that grade should have a regular review of their status because we do know of Senior Hospital Medical Officers doing consultant work. We would feel this really cannot be tackled until there has been a whole general review of hospital staffing, and as you know a Working Party has been set up to that end. I would feel, speaking broadly, the second memorandum submitted to you by the B.M.A. has dealt with this remote problem very fairly and very fully.

4989. *Sir Hugh Watson*: I read that memorandum last night in point of fact, or the night before. I would agree this is fully dealt with there. Of course, as you say the setting up of a Working Party has largely taken this matter away from this Commission.—I would feel, and most of us feel you cannot really talk about rearranged things until we have got a much greater knowledge of how things have worked so far. All we know is the present Senior Hospital Medical Officer grade has caused tremendous frustration, as has been brought out in the B.M.A. document. People who were in the service before 1948, again as I think has been emphasised very clearly in that document, feel in many cases they have been very unfairly treated vis-à-vis colleagues who before 1948 were considered their equal.

4990. *Chairman*: You said some of your other colleagues might wish to speak on this question?—*Dr. McCoull*: No, I do not think so.

4991. *Sir Hugh Watson*: There is a small point on paragraph 11. You suggest the salary of a junior hospital officer below registrar grade should be raised. I suppose you do not mean house officer grades should be given this additional remuneration because most house officers are not even fully registered?—We were thinking there, I think, of the Junior Hospital Medical Officer.—*Dr. Cotton-Cornwall*: The Junior Hospital Medical Officer. I am afraid one word has been missed out. The number of people is very limited in a more or less permanent grade.

4992. *Chairman*: I think we understand that is quite different from junior hospital officer.—I apologise, Sir. It

should be Junior Hospital Medical Officer.—*Dr. McCoull*: Could we come back on this? I am not certain where I am—I am sorry. I have got Dr. Brookes down as a person who knows something about this; I am not sure I do.—*Dr. Brookes*: I do not really. As a matter of fact I put this answer down, but the Commission's question really refers to registrars. Our answer is a little out of place. We were concerned about the salary, not of the junior hospital medical officer, but of the junior hospital officer below the registrar grade. We were concerned with the salary in relation to the charges made for these men living in hospital.

4993. *Sir Hugh Watson*: We have had that point made to us. We come now to the real body of your memorandum, which is contained in your paragraphs 15 to 20. In paragraph 20 you say for the reasons set out in the preceding paragraphs your Society argues that a medical superintendent should be given extra remuneration over and above his purely clinical colleague. We know the reasons: they are the requirement of responsibility, the burden of administrative work and the social duties attached to the post. Finally you suggest there should be something added in order to encourage recruitment in your branch of the medical profession. What exactly do you mean when you say a medical superintendent should be given extra remuneration over and above his purely clinical colleague?—*Dr. McCoull*: We think, Sir, because of all the things you mention and from the fact we are more completely whole-time than anyone else and the fact we do carry a burden of responsibility which no one else in the profession carries, that there ought to be some remuneration attached to that aspect of the job over and above what is given to us as consultants.

4994. Are you talking about a whole-time consultant?—Yes, Sir.

4995. You are, I see. Then, of course, what Bradbeer says about that is—I think he was talking about part-time consultants—a consultant who is also employed as medical superintendent should not suffer financially because of such employment. I understood that to mean he should be paid for the sessions in which he was acting as medical superintendent on the same scale at which he was paid for the sessions when he was acting as consultant. Would you agree with that?

—No, Sir.—*Dr. Skene*: I think the position is that the Ministry recognise that if a medical superintendent spends 9/11ths of his time as a consultant and the remaining part of his time in a whole-time appointment undertaking medical administrative duties, he is paid as a consultant as well. In other words he is paid as a whole-time consultant, although 2/11ths of his time is spent on medical administration. But if he only undertakes 8/11ths clinical and spends 3/11ths in medical administration duties, then of course, he is paid for his 3/11ths at lay administrative rates and not as a medical man at all.

4996. *Chairman*: He stands as a medical man for 8/11ths but not for the 3/11ths?—That is what I think, the reference in Bradbeer means, that he does not suffer providing he is predominantly a clinician—a clinician for 9/11ths of his time.

4997. Where would you draw the line? Presuming only 1/11th is clinical and 10/11ths is administrative you would not expect him to be paid entirely as a clinician?—That is so.

4998. Where would you draw the line?—I do not think I can say where the line can be drawn, except to say this, Mr. Chairman. If a man is a consultant physician for example, in a hospital of 250 beds, and is also the physician superintendent, it is quite understandable that he will be able to undertake the medical administration of that hospital in 2/11ths of his time. If he is medical administrator of a hospital of 1,250 beds, it is less likely he can undertake great responsibility and continue as a clinician and it seems anomalous that for undertaking a more important, onerous task, that he should suffer financially as compared with his colleague who is doing a similar task in a small hospital with less responsibility, which is in fact what happens under the present arrangements.

4999. Are you talking of general hospitals?—General hospitals and sanatoria.

5000. You pointed out that big general hospitals on the whole will not have medical superintendents.—My recollection of what was said, Mr. Chairman, is that a very considerable proportion of general hospitals do not have medical superintendents, or put another way a

considerable proportion of general hospital beds are not under medical superintendence. But in fact a very considerable number of the really large hospitals do in fact have medical administrators. I think I am right in saying that all the general hospitals of over 900 beds which are not, of course, teaching hospitals, do have medical administrators. That of course, raises this particular point: there is a very considerable administrative task for the medical administrator of such a large hospital and he would be the one likely to suffer if he was not prepared to undertake 9/11ths of his work clinical and 2/11ths administrative. That in fact is how it works out. I think that many medical administrators of large hospitals are managing to do 15/11ths.

5001. *Sir Hugh Watson*: It appears from Appendix F to the factual memorandum, page 79, that in point of fact consultants who do 32 hours of work, which I make to be 9 sessions, are paid as if their work were wholly clinical.—Yes, Sir.—*Dr. Skene*: May I ask for clarification? When you say consultants, you mean medical superintendents who are consultants?

5002. Yes, I mean medical superintendents who are consultants. I was talking under reference to this Appendix; you are quite right. Does that satisfy you, Dr. McCoull, or does it not?—As long as you do not think, Sir, that a medical superintendent's week is made up of 11 sessions: 9 of them clinical and the administrative work done in 7 hours, because that does not apply, not to anybody I know. It is when figures are given that are dependent on this total working week of 38 hours, that frankly I get lost because we are all working so much more time. One's working week does not end at 38 hours.

5003. Having had this very interesting discussion, what I am trying to get at now is this. In your paragraph 20 you say: "extra remuneration over and above his purely clinical colleague". What I want to know now is does Appendix F fulfil your requirements in that connection?—*Dr. McCoull*: No, Sir.

5004. It does not?—No, Sir.

5005. What do you want to substitute for it, what criteria?—We think we ought to be paid as consultants, if we are consultants, for our clinical work,

and we think because we take this added responsibility as medical superintendents there ought to be a component in our total remuneration which covers that point.

Chairman: Have you any figure in mind?

5006. *Sir Hugh Watson:* Before we come to that, with great respect, what criteria would you suggest should be employed in appraising that figure?—We have talked that over. We think there are other things than the counting of beds and heads. We do not like the counting of beds and heads very much, it makes for difficulty between small and large hospitals. But we think at the present moment that size has to count largely in any method you get, and the number of beds is as far as we have got, although we do realise there are other matters which would come into the fixing of any scale.

5007. *Chairman:* As to size, apart from the number of beds, there would be the number of out-patients?—Those are the other things. When I say beds, you have got to consider the hospital that has few beds but lots of out-patients. Each hospital with a medical superintendent would have to have a number fixed after consultation.

5008. I am trying to find what you meant when you agreed it was largely a question of size, but that it was not enough to base size on the number of beds. If it is not beds, it is out-patients?—*Dr. Cotton Cornwall:* It would be the commitments of the hospital, the type of work done. For example, the acute general hospital would have a much more rapid turnover than a mental hospital.

5009. *Sir Hugh Watson:* The criteria you would apply would differ according to the type of hospital?—I think they would have to.

5010. Can you help us any further? You say you do not like counting heads or beds,—*Dr. McCoull:* We thought, if new criteria came into being, that there must be a ceiling to anything that is awarded for this responsibility factor. Where you have got a large mental hospital with two or three thousand beds it is quite obvious there is a size over which good administration ceases, and we do not think there is any case for putting any such scale above a certain figure. We are suggesting something new, and we

have not got exact figures to put before you. We would have to have a thing like that accepted before we could give you much details.

5011. *Chairman:* I think Sir Hugh and I were both wanting to understand just what it is you have in mind and how it would work; because so far I am left with a rather vague impression of something very complicated that would be a matter of individual assessment and judgment in all cases.—*Dr. McCoull:* It would be no more complicated than in some other salary scales attached to many hospitals. There are various people in hospital I think who are paid on a points basis. I do not want to pursue this too much, because obviously I cannot give details of it, but there should not be too much complication about it. Once fixed, they would be fixed for all time.

5012. You do not want a points system?—Not necessarily.

5013. They would be assessed by various factors, varying to some extent in different kinds of hospitals?—According to the responsibility and the work done in the running of the hospital, and the size.—*Dr. Skene:* It is an attempt to equate the remuneration with the total administrative load in a particular appointment. That is not done at the moment.

5014. *Sir Hugh Watson:* Is this not somewhat comparable to the responsibility pay given to certain schoolmasters?—*Dr. McCoull:* I did not even know that schoolmasters got a responsibility payment.

5015. It is a long time since you and I were at school, but I believe the head of a department, for instance the head of a modern languages department, gets, over and above his salary as a teacher of that language, something per annum because he is responsible for a department which comprises so many staff.—*Dr. McCoull:* I would say we are thinking along those lines.

5016. *Chairman:* But the consultant is the head of a department as a rule. — He is the head of a department; but if you are thinking of a consultant at the head of his own department you are thinking of some different kind of responsibility than the responsibility which the medical superintendent has in his charge of a hospital.

5017. Just one other question; I thought I saw what you were getting at; you were saying you were nine-elevenths clinical, and it was assumed that two-elevenths is administrative; but in fact you are doing eleven-elevenths clinical and administration over and above that. Is that so?—I am not quite sure that I follow. Quite frankly, I think this nine-elevenths and two-elevenths does not count, because we are all doing more than nine-elevenths, and we are not accustomed to thinking of part-time on a sessional basis. The answer is, I suppose, on paper you could expect us to be doing nine-elevenths plus two-elevenths administration, but the answer is of course that we are doing something far more.—*Dr. Brookes*: Apart from that there is an increased responsibility in that we are not only called upon sometimes for decisions which are purely clinical, but we are also called upon frequently for administrative decisions, at any time of the day and night. It is simply that we are standing by, so we are called upon to give the administrative decisions as well as the clinical decisions. This goes on the whole time, as long as we are on the premises, and we live on the premises.

5018. *Sir Hugh Watson*: You are literally on call 24 hours a day?—*Yes*.

5019. *Dr. McCoull*, your remuneration so far has been dealt with in Whitley B, am I right?—*Dr. McCoull*: Yes.

5020. In your paragraph 14, in answer to our question XX, you say that there is general dissatisfaction with the Whitley Councils. Have you put forward this point of view from the Staff Side in Whitley B—the view you are expressing to us now?—I am quite certain we have expressed dissatisfaction from time to time with minor things, with individual items.

5021. Have you put forward this point of view about the necessity for consultants who are also medical superintendents receiving additional remuneration qua medical superintendents?—I will ask our secretary to answer that.—*Mr. Milloy*: We took this up some years ago to get the administrative salaries for medical superintendents clarified; we could not agree and went to arbitration, and the arbitration tribunal gave us a much higher salary for the purely administrative work.—

Dr. Brookes: That applied to men in the service before the appointed day, having been taken over. There was no grading then in the medical scale, so they were given an arbitrary scale which we think was grossly unfair, because they were being paid a salary before the appointed day which was higher than the salary received by those of us who have since been graded as consultants.

5022. *Sir Hugh Watson*: When you ventilated this matter at Whitley B, that was the last time this was brought up; that was some years ago?—*Mr. Milloy*: Yes, that is so. I was going to speak about it in reference to another paragraph. We are concerned with the state of some of our members who think they have been unfairly treated. There was one appointment to a large hospital shortly before the appointed day; it was considered to be a very super job, and the man who got the job was considered by all his colleagues in the service as being the best man for the job; yet after the appointed day he found himself in a worse position than his colleagues. Everybody agreed in that hospital that he had a full-time administrative job.—*Dr. Brookes*: One of the reasons why we are worried about the medical administrator and the inducement to get into medical administration, is that it is quite obvious when the Health Service came in the medical administrator was regarded as being very much inferior to his clinical colleagues.

5023. Regarded by whom?—It is difficult to say—by the very fact that he is not paid as much as the consultant—I regret to say by some of his own colleagues, part-time consultants, who do not get paid as medical superintendents. He is a person in a position, perhaps, to read the riot act occasionally to some of his colleagues, whereas the lay administrator cannot.—*Dr. Skene*: Which is no mean additional responsibility.

5024. While we are on that subject, to what extent could the functions of dealing with staff, whether medical or lay, technical or non-technical, be dealt with by a person with reasonable tact and personality and some administrative knowledge and experience?—*Dr. McCoull*: You mean without medical qualifications?

5025. Supposing you have got a man, let us say an accountant or a solicitor, who was put in as a lay administrator of a hospital, a man who had some business experience. Do you think he could, given the personality, tact, a sense of humour, understanding, deal to a very considerable extent with the problems about which you have been talking to us?—It sounds easy to say yes to that—if such a man existed, with all those qualities. But there is something in hospital life, there is something over and above all that that has to be done. Dealing with staff, yes. Is he going to be able to deal with staff when the doctors find they have not got the right staff or they have not got the right numbers of staff. There are so many questions which are so difficult for doctors to get over. There is this component in a hospital which means binding everybody together. We reckon that we have these people in the hospitals who are capable of dealing with staff, who can obtain good staff relations, who can deal with ordering the flour, getting the coal, seeing that the engines run. There is this total overall component of looking after a hospital as a whole; and frankly, I do not think an accountant or a business man or a lawyer could do it well.—*Dr. Skene*: Could I answer Sir Hugh's question? I think the paragon to whom he refers could in fact undertake these duties for a considerable part of the time; but when it came to a medical decision he would be dependent on a medical staff committee, or some medical adviser. Medical staff committees do not meet at midnight on a Saturday when a snap decision may well be required, and that is where we feel that there is undoubtedly at least the desirability of having a medical man undertaking these day-to-day responsibilities, because there is no saying when the duty becomes one for a doctor. Part of the time a competent colleague without medical training could, no doubt, undertake some part of the work. But who is to say when it may become entirely a medical question, and the answer is not obtainable at short notice on high days and holidays.—*Dr. Brookes*: An important point is that the medical administrator has an advantage over the lay administrator; but I am not saying that lay administrators are bad, because I can number among my colleagues some lay administrators who are extraordinarily

good. But the interesting thing is that they have developed a medical outlook, even to the extent of reading medical text-books, and have developed a working knowledge of the doctors' side. But that type of man is rare.

5026. *Chairman*: Have you any other point you wish to raise? If you have other points, by all means raise them.—*Mr. Milloy*: I would like to raise a point which was mentioned in paragraph 21, on behalf of a number of my colleagues. I did mention one case, but there are other cases. I think it should be considered whether any of these people who have been graded as Senior Hospital Medical Officers should not be graded as consultants. We cannot comment on the merits or the demerits . . .

5027. *Sir Hugh Watson*: I do not think that is a matter we can raise here.—*Maybe, Sir*, but it concerns the grading on which remuneration is paid.

5028. With great respect, the Chairman will no doubt give a ruling on this, I do not think we can deal with gradings, *Mr. Milloy*.—*Dr. Brookes*: I do not think we are concerned so much with the fact that these people have been given a clinical grading. These are people who are administrators and do mostly administrative work, very little clinical work; but in order to fix a rate of pay they have been given a clinical grading. That is what we are worrying about. A number of our colleagues, about seven or so, are suffering rather badly as a result of this. They were medical administrators purely and simply before the appointed day. Having come into the Health Service, they have been graded as Senior Hospital Medical Officers, to act as medical administrators; whereas before that they were on a par with those of us who were medical administrators. We do feel that they should have some consideration.

5029. *Chairman*: Can I ask *Dr. Brookes* whether it is that most of you remained about the same in remuneration, and they were down-graded, or that most of you were up-graded and a few were left?—In effect it is very difficult to say, because, frankly, I consider I was considerably better off with my salary and emoluments than than with the salary and emoluments that I am getting today. But on the whole we were up-graded on paper, and these people were left behind.—*Dr. McCoull*: There is one thing further I would like

to say. I do not know how far I am carrying my colleagues with me. In the evidence given to you by other people I cannot help feeling that this question of freedom does rather come into our pitch—such a statement that being a part-timer stops a man from feeling like an officer in Whitehall or Savile Row. I am quite certain that being whole-timers, being medical superintendents, gives us no such feeling. I do not want to feel that such statements are going unchallenged by a whole-time body of people. We do not feel like that, and I would not like any possible imputation by that sort of remark being tied up to people like ourselves.

5030. *Chairman*: You consider you are doctors as much as anybody else? —I was a general practitioner doing the work I am doing now until 1947, except for the war years. I have been a

part-time Medical Officer of Health, a general practitioner, and a part-time consultant in psychiatry. I feel just as free now as I did before; and repeatedly during the evidence that I have read I have got angered that people should think these things of us.—*Dr. Skene*: I think, if I may be permitted to express a point of view which is not unique, that one would agree absolutely with Dr. McCoull. The whole-time medical superintendents have no sense of restriction whatsoever, and it may well be due to the fact that there are other colleagues who have an option as to whether they are whole-time or part-time.

5031. *Chairman*: Thank you. If there is nothing else, that concludes this session.—*Dr. McCoull*: Could I thank you on our behalf very much indeed for having us here and being so kind and patient with us.

(The witnesses withdrew).

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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

21

Twenty-First Day, Friday, 31st October, 1958

WITNESSES

Joint Consultants' Committee

LONDON

HER MAJESTY'S STATIONERY OFFICE

1959

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TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

TWENTY-FIRST DAY

Friday, 31st October, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

Mrs. K. M. C. BAXTER

Mr. A. D. BONHAM CARTER, T.D.

Mr. J. H. GUNLAKE, C.B.E., F.I.A., F.S.S.

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Mr. W. A. FULLER, D.S.C. } *Joint Secretaries*
Mr. J. B. HUME }

Explanatory Note by the Royal Commission

The following list of topics was drawn up by the Royal Commission and issued, along with an invitation to submit evidence, to all representative medical organisations:—

- (i) The quality and quantity of recruits (a) offering themselves and (b) accepted for training as medical students.
- (ii) The quantity and quality of newly qualified doctors.
- (iii) Wastage of men and women during training and in the first few years after qualification with any remarks on incidence and causation.
- (iv) The cost and duration of training and the extent to which the cost is or should be met from grants (including both the adequacy of the grants and the proportion of students receiving them).
- (v) The position and prospects of a newly qualified doctor.
- (vi) Any trend to excessive resort to certain branches of the profession at the cost of others.
- (vii) The relative advantages and disadvantages, financial and otherwise, of service as:—
 - (a) a principal in single-handed general practice.
 - (b) a partner in general practice.
 - (c) a whole-time consultant in the National Health Service.
 - (d) a part-time consultant with the maximum number of sessions.
 - (e) a part-time consultant with only a few sessions.
 - (f) a Senior Hospital Medical Officer.
 - (g) a doctor in any other sort of practice or employment.
- (viii) The difficulties encountered by members of the registrar grades.
- (ix) The difficulties of entering general practice, with special reference to the position and prospects, financial and otherwise, of assistants.
- (x) The importance of private consulting practice as an incentive to entering the consultant branch of medicine.

- (xi) Expenses in general practice, how far they vary above and below the average and how far payments, e.g. towards capital, have to be made which are not allowable as expenses for Income Tax purposes.
- (xii) Comparative treatment for Income Tax purposes and in relation to expenses of whole-time and part-time consultants in the National Health Service.
- (xiii) Any anomalies in the methods of payment of any branch of the profession, e.g. maldistribution as opposed to wrong total volume.
- (xiv) Comments on the present system of calculating and distributing general practitioners' remuneration through a central pool.
- (xv) General comments on the system of merit awards and the method of allotting them, with any suggestions for an alternative system.
- (xvi) Particulars of financial stringency suffered by any classes of doctors illustrated by personal budgets of practitioners.
- (xvii) Special considerations of which account ought to be taken in discussions of medical remuneration.
- (xviii) Specific proposals for medical remuneration.
- (xix) The practicability of the profession establishing a fixed scale of payments for assistants in general practice.
- (xx) Proposals for specific machinery or procedures to be established for dealing with future discussions of medical remuneration.
- (xxi) Any factors other than remuneration which are affecting the contentment of general practitioners.

Note: The following memorandum was not submitted by the Joint Consultants' Committee as direct evidence to the Royal Commission. It was produced as an informal statement in response to the Commission's request, at an early stage of their proceedings, for a brief explanatory note on the functions of hospital medical staff below the grade of consultant.

HOSPITAL MEDICAL STAFF

The functions, responsibilities, etc., of the grades below the consultant

Senior Hospital Medical Officers

1. It was realised at the outset of the Service that some men holding permanent hospital posts, either whole or part-time and who were not of the professional standing of consultants, would have to be embodied. These consisted of two main groups: (1) medical officers of local authority hospitals and of local authority health services, such as tuberculosis officers. These were almost entirely whole-time officers; (2) general medical practitioners who held posts of some seniority in hospitals in their districts, such as physician or surgeon, but who were not of consultant quality. Such posts were not infrequent in some voluntary hospitals in provincial towns.

2. To assess the professional standing of these transferred or "taken over" medical officers professional grading committees were set up under ministerial authority, and, subsequently, owing to many requests, several appeals were heard from those who were dissatisfied.

3. There may, at times, be some overstatement of the S.H.M.O. case, as is perhaps only natural.

4. It has been a hope of consultants that the S.H.M.O. grade would decline and possibly eventually disappear. Far from this being the case it has actually tended to increase in numbers from new appointments.

5. An agreement was reached between the Joint Consultants Committee and the Ministry of Health soon after the N.H.S. had begun upon the principles that should govern new appointments to the grade; it having been found necessary to make

new appointments. A copy of this agreement, which is still valid, is attached as an appendix. It has prevented serious abuse in the making of appointments. There is no doubt that many hospital authorities would have made S.H.M.O. appointments when they should have appointed consultants, for reasons of economy. It will be seen from the agreement that hospital authorities cannot appoint S.H.M.Os. in the main clinical fields to ease the normal clinical responsibility of hospital physicians, surgeons and obstetric surgeons. The agreement does not apply to Scotland.

6. It was agreed that the S.H.M.O. grade should continue where offices did not call for consultant skills, while being posts that should be (a) senior and (b) permanent. The type of post is well defined in the attached S.H.M.O. circular.* It will be seen that the S.H.M.O. will be appointed, for example, for refractionist work in an eye hospital, but not for the full range of operative ophthalmology, such work necessitating a consultant. With the development of the service since 1948 it is probable that some changes should now be made in the S.H.M.O. regulations; e.g. the post of non-operative obstetrician is no longer needed and there is little use in the service for the S.H.M.O. diagnostic radiologist, who may well prove a menace.

7. Constant vigilance has been necessary to prevent abuse of the S.H.M.O. circular and to stop the consultant service being improperly diluted. There is no doubt this vigilance will have to be continued in the future, against dilution from more than one direction.

8. Whilst an S.H.M.O. newly appointed should not be given consultant responsibilities, some S.H.M.Os. who were transferred from hospital posts they already held in 1948 have been and are so acting. Nevertheless, this does not mean that they should thereby be re-graded as consultants. Consultant grading is a personal one, dependent upon the possession of the appropriate qualifications, training and ability.

9. The claims of some S.H.M.Os. to be paid at consultant rates because they are at present holding posts that will be filled by consultants when they retire are now under examination in Whitley. The granting of any such claims will not carry with it re-grading as consultant, which grading it must again be emphasised is a purely personal one.

10. It is most important for future efficiency of the Service that the high standards of qualification and efficiency of the consultant be rigorously maintained. Any compromise here would begin an insidiously spreading decline in the whole Service. New S.H.M.O. posts will be found most often today in pathology and psychiatry where they provide an "alternative path" to a consultant career and are often held by young men of the registrar type.

Junior Hospital Medical Officer

11. This grade was created to employ a junior type of career officer. It consists chiefly of those who were junior or comparatively junior hospital medical officers in local authority hospitals before 1948. There are no regulations beyond the Terms of Service for new appointments to this grade and few new appointments are made. All hope, and there is little doubt, that this will prove a shrinking grade that will eventually disappear.

Registrars

(a) Senior Registrars

12. These officers, together with the Registrars, are found occupying the middle field of appointments between House Officers below and Consultants above.

13. This type of officer began to appear in our teaching hospitals a little less than a century ago as modern medicine began rapidly to advance.

* Ministry of Health Circular { RHB (50) 96 } dated 3rd October, 1950.
BG (50) 88

14. He is not a career grade officer, but one holding an office of limited duration under consultant direction, pending settling down to a permanent career either as a consultant himself, if he wins a post competitively, or in some other branch of the profession.

15. A Senior Registrar holds a four-year post, renewable or extendable at present under certain conditions. The establishment of the posts in the various specialties is controlled in numbers by the Ministry of Health to adjust as far as possible the holders of posts to anticipated vacancies.

16. The Senior Registrar will almost invariably possess the higher academic qualifications of the consultant before he obtains his post. As a more senior grade than the Registrar he will be capable of assuming, under his consultant chief, more advanced duties. Even he should not work independently of a consultant chief and is to be regarded as under final consultant training. It is probable that there are too many senior registrars, especially in the main clinical streams in non-teaching hospitals, doing too much unsupervised consultant work that consultants should be appointed to undertake.

17. Much of what is said under this section applies also to the next grade—the Registrar—as, owing to the rationing of Senior Registrars, a Registrar, who belongs to an unrationed grade, has to be appointed to carry the same sort of responsibilities.

18. There are two aspects to the Senior Registrar: (1) his necessary place in the hospital staffing plan in order that the work of the hospital may be done, and (2) his position as a young and temporary officer training for consultant rank, to which he will have to attain competitively.

19. He is the direct and personal assistant to one or more consultants; he is their right-hand man. The senior registrar will probably have been a registrar for at least two years previously and before that will have held several house appointments, all these posts having been obtained in competition. He will be approaching, or may be more than, 30 years of age.

20. By working as a consultant's assistant he carries out essential work on behalf of his chief and receives advanced training by precept and example. In the clinical fields he will supervise the house officers in their initial history taking and management of cases and will instruct them. He will take decisions when matters become too serious for them. Thus he will either carry out more complex procedures himself or report the case, if necessarily urgently, to the consultant.

21. Depending upon his degree of skill the consultant will depute to him work of varying responsibility. He will deputise for the consultant for short periods—this is part of his training.

22. It will be seen that Senior Registrars consist of the exceptionally able, competitively chosen, younger men and women of the medical profession.

(b) Registrars

23. These are the next rank below that of Senior Registrar. Their two-year posts are renewable without limit. The majority probably serve for two to four years and not more. A great deal of what has been said above of the Senior Registrar's grade applies also to this younger grade. It is easier for an officer to leave the hospital service and enter, e.g. general practice, from this grade than from the more senior one. With restricted numbers of Senior Registrars the Registrar in many instances has had to be appointed to carry the same sort of responsibilities.

24. In teaching hospitals both Senior Registrars and Registrars have an important part in the teaching of students.

25. In all hospitals in both grades they play an essential part in the medical organisation of ward and out-patient work. Their duties in the special departments, such as pathology, are of similar quality.

(c) House Officers

26. These junior officers, like registrars, occupy a double role. They are recently qualified medical men and women who are adding to their efficiency by holding these postgraduate posts. On the other hand, the work they do is essential to the hospital.

27. They can be regarded as in the front line amongst the medical staff of a hospital. They are the first to see a patient upon his admission, to take the history, to make the first clinical examinations, to administer the first essential treatment. They will commonly work under the immediate supervision of a registrar, but they will be directly attached to a consultant chief as his "House" Officer and will be in frequent direct contact with him.

28. They will be his most junior personal assistants. They carry out, under supervision and instruction, all the routine treatment of patients in the wards unless it is of a degree of skill that is beyond them, and carry much responsibility for the admission of cases.

29. To increase the efficiency of all doctors it is now compulsory for every qualified man to perform one year of House appointments before he can be registered and there can be no doubt as to the wisdom of this regulation. Two six-months posts have to be held before registration in either Medicine, Surgery or Obstetrics. A third post after registration will receive higher pay. There is then available the post of Senior House Officer, of one year's duration, the duties beginning to approach those of a Registrar.

MEMORANDUM OF EVIDENCE TO THE ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

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INTRODUCTION

1. The Joint Consultants Committee was established in 1948 by agreement between the Royal Colleges, the Scottish Royal Medical Corporations, and the British Medical Association.

2. The Committee consists of 17 persons appointed as follows:

3 by the Royal College of Physicians of England

3 by the Royal College of Surgeons of London

2 by the Royal College of Obstetricians and Gynaecologists

1 by the Royal College of Physicians of Edinburgh

1 by the Royal College of Surgeons of Edinburgh

1 by the Royal Faculty of Physicians and Surgeons of Glasgow

6 by the Central Consultants and Specialists Committee of the British Medical Association.

3. From its inception the Committee has worked in close association with the representatives of hospital dental staff, who have the same terms and conditions of service as hospital medical staff. An observer appointed by the British Dental Association has attended its meetings. Recently the Committee has taken steps to improve this liaison by inviting the British Dental Association to appoint two representatives as full members of the Committee.

4. The terms of reference of the Committee are:

"To negotiate, in respect of England and Wales with the Ministry of Health, in respect of Great Britain with the Ministry of Health jointly with the Department of Health for Scotland, and in respect of Scotland through the Joint Consultants Committee (Scotland) with the Department of Health for Scotland, on all matters concerning consultants and hospital practice other than those within the scope of Committee B of the Medical Whitley Council."

5. Since 1948 the Committee has been in close touch with the Ministry, bringing to its notice problems referred to the Committee by its constituent bodies or by other medical organizations; and the Ministry has often invited the Committee's advice on the planning and development of the hospital service.

6. Matters relating to the terms and conditions of service of hospital medical staff are outside the remit of the Joint Committee and are dealt with by Committee B of the Medical Whitley Council, the Staff Side of which is appointed by the Joint Committee. In view of the close relationship which often exists between matters of policy or principle and terms and conditions of service, the Joint Committee has found it desirable to appoint its own members as the Staff Side of Committee B. Thus the members of the Joint Committee have an intimate knowledge both of the terms and conditions of service of hospital medical staff and of the many hospital problems with which the National Health Service has been confronted since its inception.

7. In preparing the following statement the Committee has tried to answer the questions posed by the Royal Commission in its notes for the guidance of bodies invited to give evidence, so far as it is within its competence to do so.

THE YOUNG DOCTOR AND HIS CHOICE OF CAREER

8. Upon qualification the young doctor has to serve for twelve months in approved hospital resident appointments before becoming eligible for full registration, which entitles him to practise his profession independently. Immediately after this probationary period the male doctor normally undertakes at the present time two years of national service, and he is thus about 27 years of age before he can take any decisive step in relation to his professional career.

9. The main fields open to him are (1) general practice; (2) hospital practice; (3) university teaching; (4) research; (5) Government or local authority employ-

ment; (6) the Armed Forces; (7) the Oversea Civil Service; (8) industrial medicine; (9) emigration. The majority choose either general or hospital practice.

10. It is possible to be engaged in more than one of these fields—for example, in hospital practice and teaching or research; but it is more difficult to-day than in former years for a doctor to undertake both general practice and hospital work.

11. The young doctor will usually begin his professional life with a decided preference for a particular branch of medicine, though he may change his plans as practical experience modifies his initial preference, or through force of circumstances. In general, under present conditions, the longer he delays his final choice, the poorer become his prospects.

12. A career in the hospital service entails a long period of training at comparatively low rates of remuneration. The prospective consultant must try to acquire higher professional qualifications, in the examinations for which only a small proportion of the candidates are ultimately successful. He must then face keen competition for appointments in the most desired branches of hospital work (medicine, surgery, and obstetrics), though the less-favoured specialties are more readily entered. Moreover, unlike the general practitioner he is compelled to retire at age 65, so that even if his pensionable income is higher his total earning career may be substantially shorter than that of the general practitioner. For the doctor who fails to obtain a consultant post a career in the hospital service carries a lower professional status, with remuneration below that of the average general practitioner; and the longer he remains in hospital practice the more difficult it becomes to transfer to any other form of practice.

13. A career in general practice involves no long period of postgraduate training in hospital, and no higher academic qualifications are necessary for entrance or advancement. The usual method of entry into general practice is by an assistantship with an established practitioner, but many doctors experience considerable difficulty in proceeding beyond this stage and becoming established as principals. Initially the income of a doctor in general practice may be higher than he would receive in the hospital service at the same age, but prospects of advancement are limited and the ultimate income is usually lower than that of the successful consultant.

14. University teaching and research appointments carry a high professional status and provide many advantages not enjoyed in the National Health Service, but the salary levels are lower than those of corresponding hospital appointments. Few graduates have Public Health, Regional Hospital Board, Government, or other administrative appointments as their primary aim immediately after registration. Many of the entrants have served previously in, for example, the Army or the Overseas Civil Service. Others have deviated, impatient and exasperated by hospital practice, or because they are unable to wait longer for a consultant appointment or an opening in general practice. With a few exceptions, these appointments offer lower remuneration than hospital practice. Industrial medicine now offers comparatively few openings. After the war many new appointments were made and so there is a high incidence of holders of such posts in low age groups, with few prospective vacancies for many years, and few new appointments being made. So low is the demand that the University of Edinburgh no longer provides a course or a diploma in Industrial Medicine.

POSTGRADUATE STUDY

15. The doctor who aspires to a career in the hospital service, with a consultant appointment as his objective, must be prepared for a long apprenticeship. Apart from the regular study required to increase his knowledge and experience, special consideration has to be given to the acquisition of higher qualifications. Every consultant must hold a higher qualification of one of the Royal Colleges and/or Universities. No appointment is made in the major specialties unless this condition has been fulfilled, and in almost every case it is an essential before appointment to the post of senior registrar. Many registrars also hold higher qualifications.

16. In general medicine the Membership of a Royal College of Physicians is the recognized qualification, in surgery the Fellowship of a Royal College of Surgeons, or alternatively a University Doctorate in Medicine or Mastership in Surgery, or the Fellowship of the Royal Faculty of Physicians and Surgeons of Glasgow. In obstetrics the Membership of the Royal College of Obstetricians and Gynaecologists is required, and in addition most consultants possess the Fellowship of a Royal College of Surgeons. In some specialties a diploma of the appropriate Faculty is required; for example, the Fellowship of the Faculty of Anaesthetists or of the Faculty of Radiology. These must be held in addition to specialist diplomas such as a Diploma in Anaesthetics or in Radiology. In general, no consultant appointment is made unless the applicant holds one or more higher qualifications in his specialty.

17. The examinations for these higher qualifications, though not competitive, are of a high standard and in general medicine and surgery the pass rate is less than one-third. In surgery the candidates for the F.R.C.S. have to pass a primary as well as a final examination.

18. It is difficult for a man to obtain higher qualifications while working in hospital. A separate period of study, during which no money is earned, is often required. This includes not only intensive reading, but also a large measure of practical and clinical work; and organized courses for the entrants to these examinations are expensive. For instance, apart from the time consumed, the approximate cost to a man who passes the primary and final F.R.C.S. examinations at the first attempt (and this is unusual) is about £140 for courses and £20 for the examination entrance fees. Because of the short tenure of junior hospital appointments, leave of absence except for a few days is not granted, and a man aiming at higher qualifications has to be prepared to support himself until he has passed the examinations and can compete for a registrar or senior registrar post.

19. It is not in the interest of anyone in the registrar or senior registrar grades to be too strictly confined to his own unit or hospital. To widen his experience he should have opportunities to study work elsewhere. He should thus be encouraged to visit other units, to take part in discussions at meetings, and to undertake original work or study. The rotation of senior registrars between central and peripheral hospitals is an important step in the training and in the dissemination of knowledge between one hospital and another. This may lead to disruption of family life and a number of difficulties encountered in moving, and hospital authorities should endeavour to minimize these problems to a far greater extent than at present by removal grants and the provision of married quarters.

20. Postgraduate study does not cease when consultant rank is reached. Continued reading of current literature and attendance at meetings are essential. It is at professional meetings that contacts are established and experiences exchanged; indeed, the discussions between individuals are sometimes more valuable than the subject-matter of the formal papers. Every consultant should be encouraged to take some part in the meetings of his specialist body, and it is a justified grievance of whole-time consultants that they are refused income-tax relief for subscriptions to these organizations and to the scientific publications.

21. Every hospital should maintain an adequate library or source of reference for its staff. This particularly applies to provincial or peripheral hospitals where the staff do not have ready access to medical libraries. At present the grants made to Hospital Management Committees by Regional Hospital Boards for this purpose are inadequate and the libraries of few hospitals are satisfactory. The majority of medical periodicals and books essential for the maintenance of professional standards have to be purchased by the individual.

22. Study leave is provided for in the Terms and Conditions of Service of hospital medical staff, but the present arrangements work very unevenly as between different hospital authorities. The main purpose of study leave is to facilitate attendance at special courses or meetings and the visitation of other hospitals in this country or abroad so that the staff may keep their knowledge and experience up to date. Study leave may be granted (1) with pay and with expenses; (2) with pay and without expenses; (3) without pay and without expenses. Hospital Boards have adopted

differing policies in dealing with applications for study leave and in a number of instances have been unsympathetic.

23. At the commencement of the Service the Ministry placed a limitation upon the total amount which Boards might (within their approved budgets) grant annually as expenses in connexion with study leave. Thus the Oxford and Cambridge Boards were allowed to expend up to £1,200 annually; the Newcastle, Leeds, Sheffield, Liverpool, South-Western, and Welsh Boards up to £1,600; and the Metropolitan, Manchester, and Birmingham Boards up to £2,000. In the case of the Boards of Governors of teaching hospitals the maximum to be allocated as expenses varied between £800 and £1,200. In 1954 the Ministry abolished these limits, at the same time indicating that it did not expect that they would normally be exceeded. The Joint Committee has no doubt that the maximum sums to be used as study leave expenses were far from generous even in 1948. The indications are that the total amount actually granted as expenses is well below the maximum originally allowed by the Ministry, and this is understandable in view of the many competing claims on the limited finances of Hospital Boards. In the opinion of the Committee a specific allocation should be made for this purpose.

24. During the past year the Central Consultants and Specialists Committee has made a detailed examination of the study-leave arrangements, and its comments and recommendations, which are endorsed by the Joint Committee, are set out as an appendix to this memorandum.

DIFFICULTIES ENCOUNTERED BY MEMBERS OF THE REGISTRAR GRADES

25. In the early years of the Service there was an excessive trend to hospital practice induced by a high intake of ex-Service "trainees" and by the anticipated expansion of the consultant service. The number of consultants in the less well-developed specialties has in fact increased, but there has been no great increase in consultant appointments in the main clinical branches, so that the junior grades in these branches have increased out of proportion to potential consultant vacancies. The excessive recruitment has now led to a falling off in the number of entrants to the hospital service. A higher proportion of those who might have become consultants in the future are now accepting appointments overseas or are being forced into other spheres of medical practice which initially they would not have chosen. Some of those who remain in the hospital service are transferring to other specialties, probably less attractive to them but offering better prospects of advancement. While this may not amount to an excessive resort to one branch of medicine at the expense of another, it means that the less-favoured specialties are absorbing those who would have been an acquisition to the main clinical branches.

26. The greatest difficulty facing doctors in the registrar grades at present is that of advancement to a settled and satisfactory career in the hospital service, or, failing that, in some other branch of medicine.

27. Many registrars and senior registrars are married, often with young children. For at least six years, and often much longer, they have to subsist on a salary which in many cases is insufficient, and their financial difficulty, coupled with their lack of security, causes grave anxiety. Many registrars and senior registrars are required to be resident in the hospital and, as most hospitals cannot offer married quarters, have to maintain a home as well as paying for hospital board and lodging. An increase in the salaries of these two grades is urgently needed.

28. Attention needs to be given also to the career prospects in these grades. Senior registrars are too numerous, in relation to the number of consultants, to have reasonable prospects of a consultant career, particularly in general medicine, general surgery, and obstetrics and gynaecology. In many branches there is a need for more consultant posts, especially in the non-teaching hospitals, and for a more efficient planning of the consultant service. This would result in a proportionate reduction in the number of senior registrars, particularly where they are undertaking duties which should be performed by consultants.

29. Steps should be taken also to facilitate the entry of hospital junior medical staff, including registrars, into general practice. Before the introduction of the Service it was considered a worthwhile preparation for the young doctor who intended to enter general practice to spend a few years in hospital appointments. Indeed, doctors with such experience were regarded with favour by established general practitioners seeking partners or assistants. This was partly a result of the greater opportunities which existed before 1948 for general practitioners to become part-time specialists and the consequent attractions to a principal of a young assistant or partner who was likely because of his qualifications and experience to enhance the standing of the practice by obtaining a hospital appointment.

30. Since the introduction of the National Health Service, however, there has been no incentive for the prospective general practitioner to extend his hospital experience beyond the compulsory pre-registration period. On the contrary, the difficulties connected with settlement in general practice tend to encourage the young doctor to spend as little time as possible in the hospital service. This affects adversely the recruitment of hospital junior staff. In many hospitals it is proving extremely difficult to obtain sufficient junior staff.

31. Clearly, the quality of general practice would be enhanced by the entry of doctors with a wide basic training in hospital work, and the termination of national service will provide an opportunity for young doctors to spend a longer period in hospital appointments without feeling that they are delaying too long the start of their ultimate professional career. It will be necessary, however, to increase the salary of post-registration appointments if doctors are to be attracted to hospital work. A greater use in hospitals of the part-time services of suitably qualified and experienced general practitioners would also act as an inducement to the young doctor to extend his hospital training at the beginning of his professional life. The Joint Committee feels strongly that the present methods of recruitment to general practice should be examined closely with a view to making it easier for the doctor who has worked for several years in hospital to transfer to this branch of medical work.

EMIGRATION

32. The profession has always had its share of those who have been attracted to seek a livelihood overseas, and in times past there have been excellent opportunities for medical graduates from the United Kingdom to settle in the younger countries of the Commonwealth. In recent years, however, the Dominion countries especially have so developed that medical men from this country face much keener competition in settling in them. Despite the changed circumstances a number of doctors, often among the most promising, frustrated in their attempts to obtain consultant appointments in the United Kingdom or dissatisfied with conditions of service at home, have emigrated since the introduction of the N.H.S.

33. What is more alarming is the high proportion of medical students who are attracted by the prospects overseas in comparison with those available in this country. A survey of student opinion conducted in the University of Edinburgh early in 1957 showed that only 36.5 per cent. of the medical students expressed a preference for work in Great Britain; 31 per cent. considered work overseas desirable; and approximately one-third were so undecided about their future prospects that they were unable to express an opinion.

34. The fact that so many members of the profession are driven to emigrate reflects dissatisfaction with the present conditions of medical practice in the United Kingdom. When this dissatisfaction spreads—as it is spreading—to students still in training for the medical profession, it bodes ill for future recruitment.

THE RELATIVE ADVANTAGES AND DISADVANTAGES OF DIFFERENT FORMS OF SERVICE

35. For the most part all junior grades of hospital medical staff are employed on a whole-time basis, the exception usually being where the practitioner is simultaneously engaged in general practice, or in research. Employment in the hospital service as a consultant or S.H.M.O., however, may be on a whole-time or part-time

basis, and the majority of consultants and many S.H.M.O.s are engaged on a part-time basis, devoting the remainder of their time to private practice.

The Whole-time Consultant

36. The whole-time consultant receives the salary of the grade as laid down in the Terms and Conditions of Service, and certain additional payments agreed as a result of past negotiations between the profession and the Ministry of Health, or in Committee B of the Medical Whitley Council. He enjoys certain financial advantages in that he avoids the heavy overhead expenses of consultant private practice and the higher cost of living that is often unavoidable for a part-time consultant. He is somewhat better off than his predecessor in the local authority hospital service in that he is permitted to receive certain fees for professional services not regarded as coming within the scope of the National Health Service Act. These will be found listed in paragraph 14 of the Terms and Conditions of Service for Hospital Medical Staff. After performing eight free domiciliary consultations per quarter, the whole-time consultant is paid for any additional consultations up to an annual maximum of 800 guineas. He also enjoys the advantage of a comparatively regular professional existence, free from the unpredictable stresses of private practice.

37. His main financial disadvantages appear to be two in number. First, he is not paid—as an addition to his salary—the expenses “necessarily and reasonably incurred” in the course of his work, as listed in paragraph 16 of the Spens Report on the Remuneration of Consultants. Negotiations on this matter have been fruitless, and in the view of the Joint Committee the Spens Report has never been implemented in this respect. Secondly, he is not given by the Inland Revenue adequate and just allowances for the professional expenses inevitable in the holding of his appointment. Possibly the most important of these is an allowance for car expenses, including depreciation in car value. It is wholly unreasonable to say that a car is anything but an absolute necessity to a whole-time consultant.

38. The great disadvantage of the whole-time consultant's position is that he lacks the sense of professional independence that is felt by a consultant not wholly dependent upon his salaried appointment.

The Consultant with a Maximum Part-time Contract

39. This type of consultant is probably the most numerous within the Service. His financial advantages are, in the main, twofold. He is free to practise privately outside the hours that he gives to his hospital work. The volume of private consulting practice has undoubtedly shrunk greatly since the introduction of the Service, but varies much between specialty and specialty, between one part of the country and another, and between one consultant and other. Broadly speaking it is undoubtedly true of the maximum part-time consultant that he is mainly dependent upon his hospital salary. He enjoys, however, a measure of professional independence. His second financial advantage is that, certainly up to the present time, he has been more justly treated by the Inland Revenue in connexion with the allowance of professional expenses than has his whole-time colleague. There has been a recent adverse change in this regard with the transfer to Schedule E of many part-time consultants as far as their hospital salaries are concerned.

40. The part-time consultant suffers in the same way as his whole-time colleague from the failure of the authorities to make payments additional to his hospital salary for professional expenses that he necessarily and reasonably incurs. He enjoys the additional payments under paragraph 14 of the Terms and Conditions of Service and payment for all domiciliary consultations up to the agreed maximum of 800 guineas per annum.

41. The advantages, both financial and non-financial, of the maximum part-time consultant are such that the great majority of consultants—over 70 per cent.—prefer this status.

The Part-time Consultant with Only a Few Sessions

42. Unless a consultant is willing and able to work continuously exceptionally long hours there is necessarily a limit to the amount of private practice he can undertake if he is engaged on a maximum part-time basis in the Service. Some of the part-time consultants with only a few sessions are senior men who are well-established and successful in private practice and wish to devote most of their time to this. These consultants are comparatively few in number and are confined to the densely populated areas. It is probably a great advantage to medicine and to the public well-being that there should be this variation between consultants in the amount of time they apportion to their private work. It is desirable that there should remain a certain number of consultants who are primarily independent professional men, living by private practice. These consultants have the whole of their incomes assessed under Schedule D, and it is to be hoped that the courts will uphold the Special Commissioners' decision that all part-time consultants should be so treated.

43. Another group of part-time consultants with only a few sessions consists of young, recently appointed men who have failed to obtain a greater number of consultant sessions. This group presents a real problem because, as they have little or no private practice, their hospital income is insufficient to maintain them. Hospital Boards find it increasingly difficult to fill vacancies with fewer than eight sessions, and many Boards strive to advertise a new post or posts with sufficient sessions to provide an adequate livelihood. One method of dealing with this problem would be to pay a rate of remuneration higher than the normal rate as permitted under paragraph 5 (e) of the Terms and Conditions of Service, this being one of the purposes for which the provision was made by the Ministry.

The Senior Hospital Medical Officer

44. Where the holder of one of these posts has undertaken a full consultant training and has acquired the higher professional qualifications of the consultant, he usually, and with justification, feels himself underpaid if he finds himself in an S.H.M.O. post doing work of consultant quality and responsibility. The Royal Commission has already been informed of a recent decision of Committee B of the Medical Whitley Council to review certain S.H.M.O. posts in which the holders are considered to be doing consultant work, in order to decide whether they should be paid at consultant rates.

45. The S.H.M.O. enjoys the same security of tenure in his appointment as the consultant. The remuneration received suffers, as in the case of consultants, in that it has had in recent years inadequate adjustment to the cost of living. The 1954 increases granted to hospital staff were maximum in their benefit to the young consultant without a merit award. The S.H.M.O. did not benefit proportionately, and there is throughout the grade great dissatisfaction regarding status, prospects, and remuneration. It would be to the benefit of the Service if the S.H.M.O. grade were to be treated as a declining one.

COMPARATIVE TREATMENT OF WHOLE-TIME AND PART-TIME CONSULTANTS FOR INCOME-TAX PURPOSES

46. Reference has been made to the distinction in the matter of income-tax assessment as between whole-time and part-time consultants, and this merits further explanation.

47. Consultants employed on a whole-time basis in the Service are assessed for income-tax purposes under Schedule E. Relief from tax in respect of expenses, under this Schedule, is governed by the rule that if the taxpayer is necessarily obliged to incur and defray out of the emoluments of the employment the expense of travelling, or otherwise to expend money "wholly, exclusively, and necessarily" in the performance of his duties, such expenses may be deducted from the taxable emoluments, but not otherwise. This rule is extremely restrictive and in practice means that the taxpayer is unlikely to succeed in claiming any expense which he is not required to incur and defray out of his remuneration as a condition of his employment. Moreover, where, in the case of car expenses, for example, rates of

mileage allowance or negotiated in the Whitley Council, no tax relief is allowed even though the doctor may be able to demonstrate that his expenses are greater than the allowance paid by his hospital board.

48. The expense of maintaining a telephone, subscriptions to learned societies, the cost of textbooks and periodicals, and the expense of attending professional meetings are not normally allowed to rank for tax relief in the case of a whole-time consultant assessed under Schedule E.

49. The Royal Commission on Taxation of Profits and Incomes commented in its Report on the position of professional persons in salaried employment, and recommended that the Schedule E rule should be amended in order to permit relief from tax in respect of expenses "reasonably incurred for the appropriate performance of the duties of the employment." If this recommendation was adopted by the Government it would go a long way towards meeting the present grievances of whole-time consultants in this matter.

50. Private consulting practice income is assessed under Schedule D, and the relevant rule governing expenses provides that no sum shall be deducted in respect of any expense not being money wholly and exclusively expended for the purpose of the profession. In practice the rule means that the rent, rates, and upkeep of professional premises, the wages of secretaries and receptionists, car and telephone expenses, subscriptions to professional bodies, and purchase of textbooks are all allowed. When the expenditure appears to confer some benefit on the taxpayer, however, objection is sometimes raised. For example, the cost of attending conferences or visiting hospitals, particularly those in other countries, is often disputed by the tax inspector for this reason.

51. At first sight it would appear that the part-time consultant is more favourably treated than his whole-time colleague in that for certain professional expenses which are common to both he alone can obtain tax relief. While this may have been true in the past, the position is somewhat different to-day. In recent years the Revenue authorities have tended to assess under Schedule E the hospital income of part-time consultants where this represents the major part of the professional income. One result of this is that tax inspectors are making a more searching examination of the expenses of private consulting practice, and often will not allow the full amount of expenses which they contend are not exclusive to the private practice. In some cases expenditure which the part-time consultant (but not the whole-time consultant) incurs (such as the salary of a secretary) is whittled down by the tax inspector on the ground that some of the work of the secretary is related to the National Health Service. This may well be true, because the part-time consultant may have to use his own secretary for some of his hospital work, and he is contacted at home and at his consulting-room in respect of public patients. But if the expense is not allowed in full because of this, he is in fact subsidizing the Health Service.

52. There is, of course, another approach to the question of expenses which, in the case of whole-time salaried employment particularly, would appear to be more appropriate than tax relief; that is, the payment of the expenses by the employing authority.

53. The Consultant Spens Committee stated that it presumed that the Inland Revenue Authorities would be prepared to consider favourably as legitimate allowances for income-tax purposes any items of expense which had been approved by a public hospital authority. This presumption has not been justified. The Spens Committee, however, also recommended that all specialists engaged either whole-time or part-time in the Service should be paid, in addition to their remuneration, any sums representing expenses necessarily and reasonably incurred in the course of their work. In the view of the Joint Consultants Committee this recommendation has never been satisfactorily implemented.

THE INCENTIVES OF PRIVATE CONSULTING PRACTICE

54. In order to understand the importance of private consulting practice it is necessary to trace its history during the present century. The kind of doctor who does nothing but consulting work is the product of a number of factors. At the beginning of the century he did not exist outside London and a few very large provincial towns, and even there his work differed from what it is now. A provincial town of 100,000 or 200,000 inhabitants could not support consultants who did nothing else. The local consulting work was therefore done by a few senior or specially qualified general practitioners who comprised the staff of the local hospital. Their hospital work, historically derived from charitable institutions, was unpaid. Its out-patient work was often supplemented by independent dispensaries, also staffed by experienced general practitioners. The general practitioner consultant physician or surgeon naturally could not give as much time to his general practice as the general practitioners who did no consulting work, but he attended a smaller number of families and often had one or two partners who were wholly engaged in general practice. Local consultants were supplemented when necessary by consultants from London or the nearest large centre.

55. Even in London in 1900, Harley Street and similar consulting centres did not exist. Consultants who staffed the teaching and other hospitals, unpaid, like their provincial colleagues, often had a consulting-room in the City where they were consulted by patients who lived in the suburbs and worked in London, and where they also acted as consultants to the insurance companies, as many still do.

56. As medicine became more complex and specialized, areas like Harley Street grew up in London and the large centres, where specialists were in easy reach of each other, and of nursing-homes and hospitals. Until the first world war, however, ancillary diagnostic aids were few and elementary. The enormous expansion of these since 1919 has, first in the United States and then here, tended to bring the consultant's consulting-room into or near his hospital, since many diagnostic and therapeutic methods are available only there.

57. Since 1948 the National Health Service has aimed at making a consultant service available throughout the country, and the general practitioner consultant has virtually disappeared.

58. It may perhaps be thought that in such circumstances private consulting work is valueless and unnecessary, and that the needs of the community could be met, and the desires of consultants satisfied, without it. That is far from the case.

59. Many consultants feel that the disappearance of private consulting work, which would make consultants solely dependent upon the State for their remuneration, would expose Medicine and the individual patient to dangers of an excessive State control, of which symptoms are even now to be detected in the Health Service. While recognizing the important part which whole-time practice plays in the Health Service, the Committee believes that the maintenance of private consulting practice is in the interest of the public welfare, and that it indirectly helps to maintain conditions of freedom and independence, even for the whole-time consultant, which would be seriously endangered if private practice were to disappear.

60. The work of the average out-patient hospital clinic is such as to limit strictly the amount of time that the consultant can devote to each patient. In an ordinary medical or surgical clinic there will often be twenty or more new patients and at least as many old ones. These have to be seen by a consultant with help which may vary from a senior registrar or registrar to a house officer. Under the Health Service these numbers are to some extent swelled by patients who have already been fully investigated at other hospitals, but having been told that nothing more can be done for them, seek a second or perhaps a third opinion. To reduce the numbers attending would be to increase the waiting-list and the delay before the patient could be seen. In present circumstances, therefore, few consultants can devote as much time as they would wish to seeing a new patient at hospital. Private practice makes it possible to see patients at greater leisure,

and hospital patients benefit indirectly from the experience in history-taking and examination gained in private practice. Moreover, there are many patients whose professional and business responsibilities involve devoting much time to advising them on many points of detail, which is quite impracticable in hospital practice, and what has been said about consultations in a consulting-room applies equally to the management of a case in a nursing-home or a private bed in a hospital.

61. The short historical review will have shown that during the present century the work of consultants has become progressively more highly specialized in its scope. There is a strong feeling among consultants that private consulting practice retains a breadth of human contact sometimes embracing several members, and sometimes several generations, of the same family, which, together with a more intimate knowledge of their personal affairs, makes a human contribution to consulting work which in fact has developed little, if at all, in hospital practice, and which many would maintain can never develop in the same way in a State-provided service.

62. The increasing complexity of modern diagnostic methods and the expense of the apparatus, together with the need for skilled assistants to carry out investigations, have made it impossible for any but the largest nursing-homes to provide facilities comparable with those of a hospital. Hence the increasing use made by consultants of hospital private beds. The Health Service Regulations dealing with private beds provide that where the costs of the private block cannot be separately calculated the charge for admission to a private bed shall be determined by estimating the average daily cost per in-patient and adding 15 per cent. for a private bed in a single room, 10 per cent. in a double-bedded room, and 5 per cent. in a multiple-bedded room. This procedure operates unfairly in several ways. For example, although the consultant's professional fees are controlled by regulation, the hospital bed charges reflect changes in the cost of living. Moreover, the bed charges are not necessarily related to the quality of the accommodation and service provided. For instance, if a hospital has to pay heavy damages as a result of losing an action for negligence, this puts up the charge for the private beds. A patient who occupies a private bed frees a bed in the public ward for another patient. Besides, he has already paid by means of contributions and through taxation for the use of a bed, if necessary, in that hospital. It seems unfair that because the bed occupied is in the private block an additional charge of 115 per cent., which is out of all proportion to the additional cost of running a private bed as compared with a public bed, should be levied upon the patient. The result is that the cost of a private bed is in few instances less than 20 guineas, and is sometimes as high as 40 guineas a week in some special hospitals. The popular demand for private beds is reflected in the surprisingly rapid expansion of provident schemes since the introduction of the Health Service, but these schemes are handicapped by the fact that, to provide full cover by meeting the exorbitant charges, they have to charge a premium which is beyond the means of many who would otherwise gladly avail themselves of this service. The Committee suggests that the fair and reasonable way to cover the cost of private hospital beds is to assess what it costs to run them over and above the cost of a public bed which the patient would otherwise occupy. It would simplify matters if a flat rate were charged for comparable accommodation throughout the country. The effect would be to enable an increasing number of people to obtain the private bed accommodation they desire, under the consultant of their choice, to encourage private practice, and to make a financial contribution to the running of the Health Service.

63. The possibility of adding to his income by private practice provides an important incentive to the consultant. The value of such incentives is already recognized in the Health Service in the system of merit awards. No one will deny that many whole-time consultants to whom whole-time work particularly appeals do their best work without the incentive of private practice. But all men are not alike and there are those to whom the rewards of private practice are a direct encouragement to do, and continue to do, the best work of which they are capable.

64. To sum up, then, the Committee would urge that private consulting practice makes a distinctive contribution to medicine which indirectly benefits the Health Service and is a means of attracting to medicine some of the most successful practitioners who, without opportunities for private practice, might well decide to seek their fortunes elsewhere.

DOMICILIARY CONSULTATION FEES

65. The Minister has an obligation under the N.H.S. Act to provide the services of specialists in the patient's home where necessary on medical grounds. Because the need for such domiciliary consultation or treatment would not be uniformly distributed as between different specialties, and because of the very considerable additional burden which such work might involve, the Spens Committee recommended that additional remuneration should accrue in respect of domiciliary work.

66. The Ministry adopted this recommendation of the Spens Committee, and the Terms and Conditions of Service introduced in 1949 included provision for the payment of the following fees:

Fee for consultation, 4 guineas with an additional fee of (1) 2 guineas where any operative procedure other than obstetric is undertaken or where the officer uses his own electrocardiograph or portable X-ray apparatus; (2) 4 guineas for an obstetric operation; the additional fee of 2 guineas or 4 guineas to be payable once only in respect of each patient for the current illness.

An additional fee of 1 guinea is also payable for a journey to a place over 20 and up to 40 road miles distant, 2 guineas for a journey to a place over 40 and up to 60 road miles distant, and so on with an additional guinea for every 20 miles.

The maximum remuneration (excluding travelling and subsistence allowances, additional mileage payments, and fees for the use of the consultant's own apparatus) is fixed at 200 guineas in any quarter or 800 guineas in any year, at the consultant's choice.

67. Subsequently it was agreed that where a consultant called in for a domiciliary consultation saw more than one patient on the same occasion and in the same residence, the consultation fee should be 4 guineas for the first case, and 2 guineas for each subsequent case, up to a maximum of 10 guineas.

68. In November, 1955, it was agreed in Committee B of the Medical Whitley Council that whole-time consultants should be entitled to domiciliary consultation fees for all visits after the first eight in any one quarter.

69. The foregoing fees have never been adjusted to take account of the fall in the value of money, and the Committee recommends that they should now be increased by 60 per cent., with a corresponding increase in the yearly maximum remuneration.

70. The Committee is also strongly of the opinion that the obligation of the whole-time consultant to perform eight domiciliary consultations per quarter without payment is unfair, and should be abolished. When the service was introduced Hospital Boards were advised by the Ministry that where whole-time consultants were required to undertake domiciliary consultations their duties should be so adjusted that this would throw no extra burden upon them. In practice the Committee understands that it has been impossible to make such an adjustment of duties, and the whole-time consultant who carries out domiciliary consultations does so as an addition to his normal duties.

SPECIAL DISTINCTION AWARDS

71. The Consultant Spens Committee expressed the view that specialists of the highest eminence should be able, in the public service, to aspire to a remuneration of the order of £5,000 (in terms of the 1939 value of money). It recommended, however, that above a certain level remuneration should be determined on the basis of personal merit, and with this objective it proposed a basic salary range,

together with a system of "special distinction awards." The intention of the Spens Committee was that 4 per cent. of all consultants should receive the highest award of £2,500 a year, a further 10 per cent. the next award of £1,500, and a further 20 per cent. the lowest award of £500 in addition to their basic salary.

72. The Minister adopted this proposal of the Spens Committee and since the beginning of the Service it is believed that special distinction awards have been made to the extent recommended. In other words, approximately one-third of consultants receive a total remuneration in excess of the basic salary scale.

73. The awards have been made, as recommended, on the advice of a pre-dominantly professional advisory committee, which obtains its information regarding the merits of individual consultants in a variety of ways. Its Chairman and Vice-Chairman spend two or three months each year travelling round England and Wales in order to gain personal knowledge of the consultants in different areas. In addition, it seeks advice from the Royal Colleges and specialist organizations, from Hospital Boards, and from selected advisers in all parts of the country. A special Scottish Subcommittee makes recommendations to the national advisory committee regarding awards to consultants in Scotland.

74. The confidential nature of these awards has been an essential part of the system, and not unnaturally this has evoked some criticism. The Committee believes that the underlying principle of rewarding the outstanding consultant on the basis of personal merit is sound; that this offers an essential incentive to consultant work; and that the present method is better than any of the alternatives.

75. The suggestion has been that the monies allotted in the form of distinction awards should be used to extend the basic salary scale. The effect would be to narrow the total remuneration range recommended by the Spens Committee. This proposal has little support among consultants. Another suggestion is that additional remuneration should be attached to certain posts (rather than to certain individuals) in the form of "responsibility payments." In this way certain posts, as heads of departments or services at specified hospitals, would be paid at a higher level. The Joint Committee can see little if any merit in this proposal.

76. At the inception of the Health Service no adjustment was made to the distinction awards recommended by the Spens Committee in order to bring them into line with the 1948 value of money. The basic salary scale for consultants, as recommended by the Spens Committee in terms of the value of money in 1939, was increased at the maximum by 10 per cent., the Spens figure of £2,500 becoming £2,750, but no corresponding addition was made to the value of the distinction awards.

77. In 1954, the consultant basic salary scale was increased by £400 at the minimum and by £350 at the maximum point in the scale. The maximum became £3,100—an increase of 24 per cent. over the original Spens figure of £2,500. Again, no addition was made to the value of the distinction awards. On the contrary, for those holding A or B awards (i.e., those of £2,500 and £1,500) the new basic salary scale was "abated" by £300 and £200 respectively, which meant that, in effect, the value of these awards was actually reduced. On this occasion the Spens "weighting" formula used in the calculation of remuneration for part-time services was also modified. This, coupled with the abatement referred to above, had the effect of reducing the total remuneration of the holders of A and B awards performing between four and seven sessions. The consultants already in this category were accordingly allowed to retain their old level of remuneration.

78. In 1954 the profession had no opportunity of negotiating an increase in the distinction awards. It was a question of "taking or leaving" what was offered by the Government, and no real negotiations took place. The Joint Committee considers that it is contrary to the interests of the Service that the differentials within the consultant grade should be narrowed progressively as a result of periodical increases in the basic salary scale without corresponding adjustments of the distinction awards. Unless the differentials envisaged by the Spens Committee are maintained, there will inevitably be in the long run an adverse effect on the standard of recruitment to the hospital service, since the financial attractions of the

service will be by no means comparable with those of other professions and occupations. For this reason the Joint Committee considers it important that the distinction awards should be increased in the same proportion as the basic salary scale at its maximum. The figure now claimed at the maximum of the basic scale is approximately £4,000, which is an increase of 60 per cent over the 1939 figure of £2,500 recommended by the Spens Committee. The Joint Committee therefore strongly recommends that each of the three distinction awards should be increased by 60 per cent. The values of the awards would then be £4,000, £2,400, and £800.

THE CONSULTANT'S LIABILITY FOR COMMITTEE WORK

79. The amount of time which a consultant in the Health Service requires to spend on committees varies greatly according to his seniority and responsibilities. The consultant who has no additional responsibilities beyond his work will need to attend the meetings of the Medical Committee of his Teaching Hospital or Hospital Management Committee, which would normally meet once a month or every two months. But even he is likely to find himself on several subcommittees, which also meet regularly; he will probably be appointed from time to time as a member of an advisory appointments committee, and he may also be a member of the Advisory Subcommittee of his Regional Hospital Board which deals with his special field of work. If he should be elected Chairman or Secretary of any of these bodies his work is at once greatly increased, for he would normally attend all subcommittee meetings and would find himself representing his committee at joint meetings with other committees concerned with common matters.

80. Members of the consultant staffs of Teaching Hospitals are, in virtue of their position, responsible for much of the work of the associated medical college. Though this is not strictly the work of the Health Service, its importance is recognized by the position of the Teaching Hospitals in the Health Service Act. Those members of the Teaching Hospital Staffs who are appointed to Boards of Governors and Academic Boards of Medical Colleges find their committee work at least doubled, and members of the staffs of Teaching Hospitals in general provide a high proportion of members of advisory appointments committees. The work is exacting and time-consuming, since it often involves travelling long distances, and it is sometimes difficult for the authorities who have to nominate the members of these committees to find sufficient suitable consultants who can devote the necessary time to it. Up to one-fifth of the membership of Boards of Governors consists of consultants nominated by the medical and dental teaching staff of the hospital, and normally upwards of 25 per cent of the members of Regional Hospital Boards and Hospital Management Committees consists of medical practitioners appointed after consultation with the profession.

81. A considerable amount of advisory work is done by consultants on committees of Regional Hospital Boards. The Joint Consultants Committee has always recognized the importance of this and desires that it should be further developed. There are medical members of the Boards themselves, and members of the Boards' main Medical Advisory Committees, of numerous subcommittees of both, and of special committees to advise the Boards on the organization of the various specialties. The North-East Metropolitan Regional Hospital Board, for example, has over 20 such specialist advisory committees. A comparatively small number of consultants who are already doing a good deal of work on Teaching Hospital and Regional Board Committees are elected by their colleagues to negotiate with the Ministry in connexion with the running of the Health Service—e.g., in the Joint Consultants Committee and Whitley Committee B.

82. Finally, exceptional duties which are only occasional, but are apt to be time-consuming, arise from the obligation to appoint consultants to Appeal Tribunals or special enquiries set up by the Ministries. Thus the committee work of consultants ranges from a minimum of perhaps two or three committees a month through that of Chairmen and Secretaries of important hospital committees, who may have several a week, to busy medical members of Regional Boards and committees of the whole profession whose committees are not only more frequent but last longer, often for a whole day at a time.

83. Part-time consultants take their full share of such committee work, much of which is undertaken outside their sessional time. It is unpaid except to the extent provided for by the "weighting" formula used in calculating the salaries of part-time consultants. This weighting was reduced in 1954 despite the fact that the volume of committee work has greatly increased since the introduction of the Health Service and is essential to its welfare.

SUPERANNUATION

84. Under the National Health Service Superannuation Scheme there are two methods of calculating pension for doctors employed in the Service. The pension of the general practitioner and part-time consultant or Senior Hospital Medical Officer is calculated by taking $1\frac{1}{2}$ per cent. of the *total remuneration during the whole period of contributory service* (up to a maximum of 45 years). The pension of a whole-time officer, however (including the whole-time consultant or S.H.M.O.), is calculated differently. For each year of contributory service, up to a maximum of 45, the practitioner receives as pension $1/80$ th of his average remuneration over the final three years of service. During the period of his career a practitioner might at different times be a whole-time and a part-time officer, and in these circumstances his pension would be aggregated by the use of the two methods.

85. Where a part-time consultant or S.H.M.O. is in contract for not less than nine notional half-days, he may apply to the Minister to direct that the alternative method—i.e., 80ths of average remuneration—shall be used to calculate his pension. Such a direction, if granted, has no retrospective effect.

86. Broadly, the two methods are designed to meet equitably the differing circumstances of whole-time and part-time service. In particular, the method of calculating the pension at $1\frac{1}{2}$ per cent of the total remuneration over the whole period of service was intended to meet the position of the practitioner who reached his peak level of remuneration in middle life, easing off his commitments before eventual retirement. In these circumstances to base the pension on the income in the final years of service might be unfair. Unfortunately, the present inflationary trend, and the fact that a merit award is normally "earned" in later life, tend to counteract any benefit of the $1\frac{1}{2}$ per cent method, and place those part-time consultants and S.H.M.O.s who together with general practitioners have their pensions assessed by this method in a very insecure position.

87. In addition, hospital medical staff, with a compulsory retiring age of 65, are unable to earn the maximum pension because they cannot complete 45 years of contributory service.

NEGOTIATING MACHINERY

88. The Whitley machinery established for the conduct of negotiations regarding terms and conditions of service has proved itself completely unsuitable for dealing with major questions, and in many respects unsatisfactory for matters of lesser importance.

89. Decisions in Whitley are reached by agreement between the Staff and Management Sides, but while in theory this offers a safeguard to staff against downward alterations in the terms of service, in practice it presents great difficulty in pressing for improvements which involve large sums of money. The Management Side members have not the final authority to reach a settlement, and this necessarily induces a sense of frustration in the Staff Side. There is no right of appeal when an impasse is reached, arbitration being possible only by mutual consent. The fact that on two occasions the Staff Side of Committee B of the Medical Whitley Council (which deals with hospital medical staff remuneration) has had to by-pass the Whitley machinery and approach the Minister direct illustrates the inherent weakness of the system.

90. Although theoretically the Management Side in Whitley consists of the representatives of the various employing bodies, in actual fact the proceedings are largely dominated directly by the Ministry and indirectly by the Treasury. At times so great has the influence of the Ministry been that the impression has been gained that proposals are not considered on their merits but rather from the point of view of the impact that they may have upon the economic situation generally. The Minister, as the ultimate employer and paymaster, has through his officers on the Management Side the opportunity of influencing the course of negotiation to a large degree, whilst reserving to himself the power of subsequent veto. This state of affairs must inevitably prejudice negotiations in Whitley from the start.

91. Theoretically, Whitley machinery should provide the means whereby both sides state their case and, by a process of give and take, reach a solution which is acceptable to both. In practice, and particularly on major issues involving finance negotiation in the true sense of the word does not occur. Indeed, it is obvious from such discussions as have taken place that the Management Side has agreed to a particular line of action prior to meeting the Staff Side and, without further private consultation, has felt unable to retreat from the position it has taken up. Thus the proceedings take the form of an offer or claim being made by the one side and its rejection or acceptance by the other.

92. The Whitley arrangements place the Minister in a most advantageous position. Whilst, through his officers, he continues to exert a very full measure of control over the discussions and decisions reached in Whitley, he can when challenged in Parliament on any particular issue resort to the comfortable reply that it would be inappropriate for him to comment upon, or in any way prejudice, discussions which are going on in Whitley. In effect the Minister enjoys the best of both worlds, and Whitley provides him with a convenient screen for resisting pay claims and for giving effect to whatever he considers to be the right solution to a particular problem.

93. If the course of Whitley could be directed towards negotiations in the accepted sense of the term it might quickly become a more useful channel for settling disputes of a minor nature. There are, however, strong arguments in support of direct negotiation when major matters of finance or other questions of national importance are involved.

94. To sum up, the Committee considers that there is a place for Whitleyism as a mechanism for negotiating terms and conditions of service, particularly those of a minor character, but that if the Whitley machinery is to continue it should be drastically overhauled. In particular the Committee would recommend that the Management Side should be composed of Government officers—of the Ministry of Health and the Treasury—with real authority to negotiate with the Staff Side.

95. In addition the Committee recommends that there should be set up a small advisory committee of eminent lay persons appointed by the Prime Minister in consultation with the profession, to keep under continuous review the general level of remuneration of doctors engaged in the National Health Service in order to maintain their proper economic and social status in the community. This body should be charged with the continuing duty of tendering advice to the Government on its own initiative, but should also consider and present its findings upon issues specifically referred to it by the profession or by the Government; for example, after normal negotiations between the Government and the profession have broken down. In the event of a reference to the advisory committee both parties should have the right to present a case and to be represented at the hearing.

96. The Committee would hope that normally the recommendations of such an advisory committee would be acceptable both to the Government and to the profession, though neither side could bind itself in advance to accept the findings of the advisory committee and both sides would have to reserve their right to freedom of action in the event of disagreement.

SPECIAL CONSIDERATIONS AFFECTING MEDICAL REMUNERATION

97. In the foregoing paragraphs the Committee has endeavoured to deal with some of the matters on which the Royal Commission has specifically asked for information, and which in one way or another have a bearing on the question of the proper levels of remuneration of doctors engaged in the hospital and consultant services. In addition the Committee suggests that the following considerations are directly relevant to this question.

Length of Training

98. The period of training for a medical career in the hospital service is considerably longer and more exacting than that for most other occupations, and this must be taken into account in considering the financial rewards to be provided.

Lack of Security in the Early Years

99. The young doctor who aspires to become a consultant must be prepared to undergo the necessary training in hospital appointments of limited duration, ranging from six months to four years, appointments of over one year normally being renewed annually. He has no security until, normally between the ages of 32 and 40, he achieves the rank of consultant or S.H.M.O. He has to face the frequent movement of his home from place to place and often separation from his family for long periods. His chances of promotion are always problematical in the face of the keenest competition, and at any time he may find himself unable to secure another hospital appointment. It is therefore essential to offer terms and conditions of service which are sufficiently attractive to induce young practitioners to accept the risks involved in seeking a consultant career.

CONCLUSIONS

100. In recommending levels of remuneration for consultants and other doctors engaged in the hospital service the Spens Committee had regard to the incomes which consultants had been able to earn under conditions of private practice. If the medical profession is to continue to attract candidates of the best quality it is essential that the financial rewards should be adequate, and the Committee considers that this would be achieved by bringing the Spens levels of remuneration up to date.

101. As the Royal Commission will be aware from the claim submitted to the Government on behalf of the profession in 1956, the general practitioners regard the Danckwerts Award as having brought their remuneration, as determined by their Spens Committee, into line with the value of money in 1951.

102. In April, 1954, the salaries of hospital medical staffs were adjusted with the intention of restoring the balance of remuneration as between general practitioners and consultants which had been disturbed by the Danckwerts Award, and with certain qualifications the Committee accepts the 1954 adjustment as having brought the basic remuneration of hospital medical staff into line with that of general practitioners as at 1951. The Committee urges, therefore, that the salaries of hospital medical staff should now be further increased by 29 per cent. to offset the fall in the value of money between 1951 and 1957, and to maintain the economic position of doctors in relation to other professions.

103. Consideration should also be given to the position of consultants holding distinction awards. As previously explained, the distinction awards still stand at the 1939 values recommended by the Spens Committee, no betterment having been added at any time, apart from the addition of 8 per cent. in the form of the Government's superannuation contribution. The Committee is strongly of the opinion that these awards, which are an element of remuneration, and count for superannuation, should not be excluded from consideration in making such adjustments in remuneration as are deemed necessary by changes in the value of money. The Committee therefore urges that the three distinction awards should now be increased by 60 per cent. The Committee also recommends that the abatement of the basic salary applied to consultants with A and B distinction awards in 1954 should now be abolished.

104. The effect of the Committee's recommendations is shown in the table below:

	<i>Spens Scales</i>	<i>Terms of Service 1948</i>	<i>1954 Award</i>	<i>1957 Interim Adjustment</i>	<i>Scales Recommended</i>
Consultant with "A" Distinction Award.	£4,000-£5,000	£4,200-£5,250	£4,300-£5,300	£4,405-£5,455	£6,709-£7,999
Consultant with "B" Distinction Award.	£3,000-£4,000	£3,200-£4,250	£3,400-£4,400	£3,505-£4,555	£5,109-£6,399
Consultant with "C" Distinction Award.	£2,000-£3,000	£2,200-£3,250	£2,600-£3,600	£2,705-£3,755	£3,509-£4,799
Consultant on basic scale.	£1,500-£2,500	£1,700-£2,750	£2,100-£3,100	£2,205-£3,255	£2,709-£3,999
S.H.M.O. ...	—	£1,300-£1,750	£1,575-£2,025	£1,653 15s.- £2,126 15s.	£2,031 15s.- £2,612 5s.
Senior Registrar ...	£900-£1,200	£1,000-£1,300	£1,100-£1,400	£1,210-£1,540	£1,419-£1,806
Registrar ...	£700-£800	£775-£890	£850-£965	£935- £1,061 10s.	£1,096 10s.- £1,244 17s. 6d.
J.H.M.O. ...	—	£700-£1,000	£775-£1,075	£852 10s. £1,182 10s.	£999 15s.- £1,386 15s.
Senior House Officer...	£600	£670	£745	£819 10s.	£950
House Officer ...	—	£350 £400 £450	£425 £475 £525	£467 10s. £522 10s. £577 10s.	Pro-reg. £550 2nd yr. £650 £780

(The foregoing scales are for whole-time employment)

March, 1958.

APPENDIX

MEMORANDUM BY THE CENTRAL CONSULTANTS AND SPECIALISTS COMMITTEE UPON THE QUESTION OF STUDY LEAVE

1. Although individual considerations must always be involved in every application for study leave, a regional survey of study leave conditions has revealed differences in the practice of granting leave and expenses so great as to result in substantial injustices, and to call for an attempt to obtain agreement with the Ministry of Health on more uniform and equitable standards.

2. The Committee regards study leave as being applicable to Consultants, S.H.M.O.s, Senior Registrars, Registrars, and J.H.M.O.s, whole or part-time.

3. In R.H.B.(50)49, H.M.C.(50)48, B.G.(50)43 (hereafter referred to as R.H.B.(50)49, a copy of which is included in the Sub-Appendix to this memorandum) advice was offered by the Ministry to boards to help them in adjudicating on applications for study leave, and of the factors they were advised to take into consideration. Similar advice was given by the Department of Health for Scotland in R.H.B.(S)(51)3. The first and the most emphasized was "the possible advantage to the National Health Service generally, and the board's own specialist services in particular, of granting the application."

4. It must be accepted that one purpose of study leave is to foster professional knowledge and skill from which the patient will certainly obtain benefit, and if the patient, then presumably the National Health Service and the board's services also. But this result is an indirect one and ought not to be placed as the primary consideration in granting study leave—or to be used possibly as a basis for refusal to which no very satisfactory reply is possible on the part of the applicant (even if he knows that objection has been raised!). To make this principle so prominent is to infringe an important principle of the Spens Report and to sap the scientific status of the consultant profession which the Spens Report was seeking to uphold.

5. Study leave is essentially a provision made in the interests of the patient for maintaining the scientific position of the doctor and must not be regarded as having any other professional purpose. Lay members of boards and committees, unfamiliar with this essential medical need and, therefore, possibly sceptical as to the purpose and value of study leave, must be made aware of its importance.

6. The need for discussion of medical ideas and practice began to be apparent to the leaders of the profession as soon as the body of scientific developments began to form in the second half of the 19th century. Specialist societies began to be founded and were, in general, selective in membership so that the time available for meetings might be used most economically. Though excellent medical journals existed then, it was recognized that they did not alone serve all the needs of professional inter-communication, and regional, national and later international societies were established for this purpose. It is universally accepted in the profession that the meetings of these perform an important—even essential—service to medical progress and that to deprive any member of intermediate and senior hospital medical staff of the opportunity to attend regularly such meetings as are appropriate in his specialty is to inflict an irreparable professional injury. For this reason the Committee recommends the rejection of paragraph 3 (e) of R.H.B.(50)49 which states that among the factors to be taken into consideration when dealing with applications for study leave are "the opportunities, or lack of opportunities, of the applicant to keep abreast of his subject apart from study leave." It is appreciated, however, that in practice some restraint on the universal granting of study leave may be necessary.

7. Though, in practice, some restraint on the granting of study leave may occasionally be necessary, in order to maintain a fully adequate service, it is the view of the Committee that the principle which should be applied should be that study leave is granted whenever possible, and that boards should expect all members of their medical staff (except the house officers) to apply for study leave with some frequency, even to the point of prompting those who appear reluctant to do so.

Thus boards will be helping effectively to combat the small but real danger of medical isolation and stagnation in their services.

8. Paragraph (6) of R.H.B.(50)49 reads as follows:

"6. When practitioners take an active part in scientific or clinical conferences or meetings of societies by holding office, reading papers or giving demonstrations, sympathetic consideration should be given to requests for grants towards expenses. Members of most scientific societies which meet regularly are able to choose the meeting at which they will present a paper or demonstration, and it should often be possible for them to select (with regard to time and place) the meeting which can be attended with the least inconvenience and expense to the service."

9. This introduces conceptions of study leave expense grants which by their implications are in the view of the Committee too restrictive.

10. It is, in general, the meetings where the greatest expenses are involved that should call for the most liberal allowance of expenses. This is, of course, especially true of the meetings of international conferences abroad. The Committee considers that expense grants should not be limited to those who are to hold office, read papers or give demonstrations at medical meetings. Obviously the claims of these are most cogent, but valuable contributions are often made during the course of discussion by others attending meetings, and all who attend receive benefit whether they contribute or not.

11. Another group of medical staff which has to meet heavy expenses includes those who work in distant peripheral areas such as Northern Scotland and Northern Ireland and who may be debarred from attending meetings if they must meet the total expenses themselves. In regard to expenses generally, the needs of junior officers should receive special sympathy.

12. The Committee is of the opinion that the annual sums at present made available for study leave expenses are insufficient, especially in view of the considerable fall in the value of money since 1948 and the increase of senior medical staff and senior registrars, and boards should be advised to make substantially greater sums available for the purpose (at least double the sums originally allocated (before H.M.(54)28)). Where the total of permitted expenses claimed for study leave exceeds this annual allocated sum, each claimant should receive such proportion of his total annual claims as will reduce the total of all expense grants to the annual sum allocated, with resulting fairness to all concerned. This arrangement also obviates the penalizing of those whose applications are made late in the financial year when a fixed fund might have been exhausted. Where such reduction has to be made, a

statement of the gross overall claims and the percentage reduction should be issued to claimants at the time of payment.

13. The Committee would draw special attention to the need for study leave for members of the medical staff of small hospitals which are geographically remote. In para. (4) of R.H.B.(50)49 their special need for study leave is emphasized. Often the difficulty which makes granting of leave to them almost impossible at present is that no deputy is available. The Committee therefore recommends that the Ministry should be asked to advise boards to keep an adequate list of locum consultants and S.H.M.O.s who could be called upon to act under these conditions. It would be manifest injustice to compel the consultant or S.H.M.O. concerned to pay the locum himself or forego his own pay. Proportionately greater sums for expenses are needed in these remote areas.

14. The Committee recommends that applications for study leave should always be first considered by a medical committee appointed for the purpose by the board. In para. (5) of R.H.B.(50)49 boards are informed that they should seek the advice of their medical committees. This wise and obviously necessary procedure still does not obtain in some areas.

15. There is a widespread feeling that sometimes some study leave advisory committees, including some medical ones, exercise their function without a full regard to the basic equality of opportunity which should be offered to all senior medical staff to enjoy the privilege of study leave. Priority considerations are said to be based on personal prestige or other irrelevant criteria, so that the granting of leave with pay (with or without expenses) is very unevenly distributed. While the Committee thinks that such a state of affairs must be exceptional it is clear that study leave advisory medical committees ought to have a membership representative of all grades of staffs concerned with study leave.

16. The Committee has already commented on certain paragraphs of R.H.B.(50)49 and wishes to make the following additional observations:

- (i) Paragraph 3a advises boards and committees when considering applications for study leave to take into consideration "the suitability of the applicant to benefit from the proposed leave." It is suggested that the Ministry should be asked to define the word "suitability."
- (ii) Paragraph 3d advises boards and committees when considering applications for study leave to take into consideration "the number of applications from the region or hospital for any particular course or meeting." It is suggested that the Ministry should be asked to add the words "should not be limited except to ensure efficient maintenance of the Service."
- (iii) The last sentence of paragraph 5 reads as follows: "consequently there will need to be discrimination not only between individual applicants but also between courses or conferences of a similar nature." It is suggested that it should be amended to read as follows: "There will *sometimes* need to be discrimination . . . in order to maintain the efficiency of the Service."
- (iv) Paragraph 8 reads as follows: "Where a society holds regular one or two day meetings, it may be necessary to apportion leave periods to ensure that all officers who are members of the society are given facilities to attend a reasonable proportion of meetings, should they so desire." It is suggested that the following phrase should be added to this paragraph: "provided that permission to attend should not be withheld except to ensure the maintenance of an efficient service."
- (v) Paragraph 9—third sentence reads as follows: "While giving due weight to the advantages to be gained from meeting colleagues abroad either socially or professionally, boards should be satisfied, before granting leave with pay in these cases, that the object of the visit is serious planned study from which the National Health Service will derive benefit." The emphasis should be on the knowledge and experience gained, and it is therefore suggested that the latter part of the sentence should read as follows: "that the object of the visit is serious planned study from which the National Health Service may be expected to derive benefit from the increased knowledge and skill of the staff concerned."

FURTHER RECOMMENDATIONS

17. The Committee recommends that the general principles stated below should be adopted by hospital boards in dealing with applications for study leave, there being no discrimination as between whole-time and part-time officers. All applications should be considered by the medical advisory committee of the board suitably augmented by representatives of the grades concerned, or a similar *ad hoc* body, on which all categories of medical staff concerned should be represented. This Committee should make recommendations to the board, having regard to the suitability of the conference or study leave project.

(a) Leave for the Purpose of Taking an Examination

The Committee supports the practice commonly followed in connexion with leave for the purpose of taking examinations, namely, that examinees should be granted leave with pay but without expenses.

For many junior officers, especially those in small peripheral hospitals, a short intensive course of study may be both necessary and desirable before taking a higher examination, and, in view of the pressure and continuous work in such posts, may be the only practicable way in which instruction can be obtained. It is therefore recommended that paragraph 10 of R.H.B.(50)49 which states that if leave is granted for short intensive courses which have examination success as their sole aim it should be without pay, should be revised, and boards should consider such applications sympathetically with a view to granting study leave with pay.

(b) Leave for Examining

The Committee also supports the present practice in regard to leave for the purpose of examining—namely, that examiners should be granted leave with pay but without expenses.

(c) Leave of Short Duration for Attendance at Specialist Society Meetings

Leave with pay to attend conferences of short duration should be freely granted provided adequate arrangements can be made for the officer's duties to be covered during absence, bearing in mind the special difficulties of those who are isolated.

Travelling and subsistence allowances should also be granted according to the principles recommended above, and the granting of such expenses should not necessarily be related to the reading of papers at conferences.

(d) Leave of Longer Duration for Attendance at Conferences in Great Britain

Leave with pay should be granted for a period, or periods, up to a maximum of 18 days in one year or 30 days in two years, except in special circumstances when leave in excess of this might be granted by the board concerned. The question of expenses should be determined according to circumstances.

(e) Leave to Travel Abroad to Attend International Meetings or to Visit Hospitals

Leave with pay and expenses should be granted for a period, or periods, up to a maximum of 28 days in one year without any deduction being made from annual leave. Only in special circumstances should such leave be granted more than once in two years.

Under the present Terms and Conditions of Service, where leave is granted for a period in excess of three weeks, half of the excess is counted against the annual leave entitlement, and for this purpose an officer is allowed to carry forward from the immediately preceding year annual leave not exceeding three weeks. It is recommended that the Ministry should be approached with a view to extension of the present terms to enable officers to take longer periods of leave abroad. Officers might be entitled to carry on from year to year unexpended annual leave entitlement up to a maximum of 10 weeks to augment study leave allotment for purposes of a prolonged tour of foreign hospitals and medical clinics, etc., provided the board agrees and the standard of the hospital service is not thereby impaired.

(f) Leave for Special Purposes

Where special leave is required for the purpose of complying with requests from the British Council, or other national bodies, the question of study leave, expenses, etc., should be determined on an *ad hoc* basis between the officer and the board concerned.

Locums for Officers Absent on Study Leave

18. On the question of locums to carry out the duties of those granted study leave, the Committee agrees with the present policy of employing authorities that the employment of a locum should not be necessary where the duties can be covered by colleagues during absence.

19. There is, however, a real problem in certain specialties and in certain areas where it is impracticable for the duties of the absentee to be covered by officers already employed by hospital boards. Where this applies officers may be denied any period of study leave, and it is often these to whom attendance at a conference or course is of the greatest value because the teaching centres are normally inaccessible to them. The Committee therefore recommends that, in such circumstances, employing authorities should engage a locum in order that the officer may be free for a period of study leave.

20. It is also recommended that hospital boards should maintain a register of those who would be available for locum duties of this nature.

Allocation of Expenses

21. In the early years of the National Health Service there were allocated to boards, for distribution annually, sums specially earmarked for payment of expenses in connexion with study leave. In 1954 this practice was discontinued. Since that time, it appears that boards have been unwilling to exceed the maximum previously allowed or even to equal it, in spite of the fact that the value of money has decreased. The Committee considers that the Ministry should be asked to make it clear to hospital boards that the original maxima should be at least doubled in view of the decreased value of money and the increase of medical personnel. It would seem practicable that each hospital board should earmark a sum of sufficient size to cover the study leave needs of the medical staff employed in the hospital service in the region, but as there is no fixed annual maximum applications for study leave with expenses should receive careful consideration at whatever time of the year they are made, and should not be related entirely to amounts already granted earlier in the financial year.

22. In some cases, where hospital boards do not defray travelling and subsistence expenses in full, it is recommended that for the benefit of those officers who are thus involved in considerable personal expense, the Ministry of Health should be urged to seek an agreement with the Board of Inland Revenue whereby such expenses in connexion with study leave may be regarded as legitimate professional expenditure in respect of income-tax assessment.

SUB-APPENDIX

R.H.B.(50)49

H.M.C.(50)48

B.G.(50)43

HOSPITAL MEDICAL AND DENTAL STAFF

TERMS AND CONDITIONS OF SERVICE: STUDY LEAVE

1. This memorandum has been prepared to give guidance on the granting of study leave and to supplement the observations on the operation of the study leave scheme which were made in paragraphs 73 to 80 of R.H.B.(49)85, H.M.C.(49)70, B.G.(49)71. It is hoped that it will help boards to deal with applications for study leave, but it is not meant to be interpreted as a rigid set of instructions and does not presume to cover all possible types of application.

2. The purposes for which study leave may be allowed are set out in paragraph 18 (d) (i) of the Terms and Conditions of Service; it cannot be claimed as a right, and while it is intended to be available to all grades of medical and dental officers at the discretion of the employing body the Department will not expect to find more than a few exceptional cases where it will be justified for House Officers, or, except in the circumstances referred to in paragraph 11 below, for Junior Registrars.

3. In dealing with applications for study leave, the board or committee and its medical advisory committee should take the following factors into consideration:

- (a) the possible advantages to the National Health Service generally, and to the board's own specialist services in particular, of granting the application,
- (b) the suitability of the applicant to benefit from the proposed leave,
- (c) the nature and function of the course, meeting or conference for which leave is asked, e.g., scientific, clinical, medico-political, social or any combination of these activities,
- (d) the number of applications from the region or hospital for any particular course or meeting,
- (e) the opportunities, or lack of opportunities, of the applicant to keep abreast of his subject apart from study leave,
- (f) the frequency of application of any one individual,
- (g) the arrangement of deputies during the absence of officers,
- (h) the views of other boards with whom the applicant is in contract.

4. Members of the staff of small hospitals which are geographically isolated find it more difficult to keep in touch with recent advances than do those in the regional centre. This isolation should be counteracted as far as possible by visits to and from senior members of staff and by meetings in the centre. It will, however, often be a factor in favour of study leave.

5. Boards will recognize that courses of instruction, scientific meetings, and conferences differ widely in the value of their contributions to medical science and to the educational advancement of those attending. It would be invidious to attempt any detailed differentiation in this document, and boards should seek the advice of their medical committees on the nature, purpose, and relative value of courses, etc. It has been the Department's view that study leave with pay will normally be justified for meetings of the specialist associations, but, generally, the status of the society or conference should not be the sole consideration and often not the primary consideration in deciding whether study leave should be granted; study leave is always subject to the exigencies of the service, and the other factors in paragraph 3 (particularly (a) and (b)) have to be given due weight. Consequently there will need to be discrimination not only between individual applicants but also between courses or conferences of a similar nature.

6. When practitioners take an active part in scientific or clinical conferences or meetings of societies by holding office, reading papers, or giving demonstrations, sympathetic consideration should be given to requests for grants towards expenses. Members of most scientific societies which meet regularly are able to choose the meeting at which they will present a paper or demonstration, and it should often be possible for them to select (with regard to time and place) the meeting which can be attended with the least inconvenience and expense to the service.

7. When medico-political or social activities are combined with scientific or clinical meetings and are likely to occupy a proportion of what may reasonably be considered to be "working hours," the allotment of study leave, if granted, should be related to the duration of the clinical and scientific activities; it is not unreasonable to expect the applicant to devote a part of his annual leave to that part of the period given over to other activities and to relaxation.

8. Where a society holds regular one or two day meetings, it may be necessary to apportion leave periods to ensure that all officers who are members of the society are given facilities to attend a reasonable proportion of meetings, should they so desire.

9. A difficult problem is sometimes presented by individuals or unofficial groups who wish to make a tour of hospitals or clinics abroad. Before the introduction of the National Health Service these trips were usually undertaken at the traveller's own expense, and in part, at least, were looked upon as a relaxation; six weeks' annual leave with pay was not then available. While giving due weight to the advantages to be gained from meeting colleagues abroad either socially or professionally, boards should be satisfied, before granting leave with pay in these cases, that the object of the visit is serious planned study from which the National Health Service will derive benefit; and, as suggested in paragraph 7 above, it would not be unreasonable to expect the applicant to devote a fraction of his annual leave to any part of the period which is given over to relaxation.

10. Within the registrar grades (but not ordinarily during the first year as Junior Registrar) some applications may be received for leave to attend postgraduate courses of instruction. Courses organized on an educational basis will benefit both the individual and the National Health Service, and leave with pay will often be appropriate; but short intensive courses ("cram courses") which have examination success as their sole aim should not be included in this category, and if leave is granted it should be without pay.

11. Leave without pay for six months or occasionally a year may be granted to registrars wishing to take an academic or other paid appointment for the purpose of special study or research in a university department.

12. Applications for prolonged leave will occasionally be made by officers intending to work in a hospital or laboratory abroad. In these and in other cases of application for leave abroad, the board should be satisfied (a) that the applicant has had such training in this country as will enable him to profit by his experience abroad and to assess critically the value of what he learns, and (b) that he is, from all points of view, likely to maintain the prestige of British medicine abroad. In general, it is preferable that leave for the purpose of working in hospitals abroad should be sponsored by a recognized postgraduate or research organization or by a national or international body awarding Fellowships. The applicant should be at least of Senior Registrar status.

13. In some cases applications for prolonged leave may be made for the purpose of keeping alive superannuation rights. It should be borne in mind that prolonged leave is not the only method of preserving superannuation rights, as the Minister has power, under section 19 of the National Health Service Amendment Acts, 1949, to recognize work elsewhere than in National Health Service Hospitals in suitable cases as "approved" service for superannuation purposes.

14. In determining the allocation of expenses, it has to be remembered that the funds available for this purpose are not unlimited and that discrimination is unavoidable if they are to be used to the best advantage.

15. The Minister has discussed with the Joint Committee arrangements for the granting of leave to hospital medical staff for the purpose of examining, and it has been agreed that the Terms and Conditions of Service of Hospital Medical and Dental Staff should be amended as follows:

Paragraph 18 (d) (ii) (B) (c)

Insert at beginning of (c): "Except in the case of leave granted to officers in order to allow them to act as examiners in examinations held by universities or medical corporations for the purpose of granting medical or dental degrees or diplomas."

Ministry of Health,
Whitehall, S.W.1.

June 8, 1950.

94111/3/5.

SUPPLEMENTARY MEMORANDUM OF EVIDENCE TO THE ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

Representatives of the Joint Committee gave oral evidence before the Royal Commission on the 18th December, and on that occasion the Commission put to the Committee's representatives a number of questions on which it wished to have further information.

The Committee has considered the various points raised by the Royal Commission, and its comments upon them are set out below:—

Q. References are to the Royal Commission's published Minutes of Evidence, Day 2.

A. Q. 354

Question:

It would appear that since the beginning of the Health Service the number of consultants has increased while the number of general practitioners has remained relatively stationary. Has the Joint Committee any views as to the appropriate relative numbers of consultants and general practitioners?

Comment:

(1) The Committee does not consider it practicable that the relative numbers of general practitioners and consultants should be determined in an arbitrary manner. Indeed, it does not believe that the appropriate numbers in each field are necessarily interdependent.

(2) It is not difficult, however, to account for the proportionately greater increase in the consultant field which has taken place in recent years. There has been a publicly organised general practitioner service, covering a substantial proportion of the community, since 1911. In addition to the National Health Insurance Scheme there were many local medical clubs (often organised by the general practitioners themselves) through which by a system of small weekly or monthly payments general medical treatment was made available to the wives and families of working class people. Long before 1948, therefore, the community as a whole had the benefit of a family doctor service, which paved the way for the introduction of the National Health Service in this field.

(3) As explained in the Committee's memorandum of evidence, the growth of consultant practice is a much more recent development.

(4) Before the Health Service consultants devoted a considerable proportion of their time, without payment, to the hospital treatment of the poorer classes, and they depended largely for their professional livelihood upon fees received for the treatment of wealthier people. This, of itself, necessarily limited the number of doctors who could make a financially successful career in consultant practice.

(5) Quite apart from the social change which has taken place, however, a more significant reason for the growth of consultant practice has been the advance in medicine and the introduction of new techniques in the past 20–25 years. Since 1939, and more particularly since 1948, hospitals in the smaller towns and country areas have developed into institutions providing a full range of consultant advice and treatment with all the necessary ancillary facilities. This has inevitably involved a substantial increase in the number of consultants, particularly in certain branches. One of the objects of the Health Service was the provision of a consultant service throughout Great Britain, and this has been substantially though not, in the opinion of the Committee, fully achieved.

B. Q. 380

Question:

Page 64 of the Ministry's memorandum of evidence shows the trend in the establishment of registrars and senior registrars. Will the Joint Committee comment on this?

(Note: The figures quoted in the Ministry's memorandum are as follows:—

	1951	1952	1953	1954	1955	Increase or decrease	
						No.	Per cent.
Senior Registrars ...	1,547	1,296	1,195	1,253	1,262	-285	-18.45
Registrars ...	1,856	2,111	2,259	2,446	2,620	+764	+41.2

Comment:

(6) The reduction which has taken place in the number of senior registrars since 1951 is the result of the Ministry's policy (agreed with the Joint Committee) to endeavour to relate the numbers of senior registrars in training for consultant posts to the number of anticipated consultant vacancies. This reduction has been made largely at the expense of non-teaching hospitals, and there is little reason to doubt that it accounts in part for the corresponding increase in registrar appointments in such hospitals.

(7) Despite the reduction in senior registrars there are still in certain specialties many more fully trained men than there are consultant vacancies. The Committee is firmly of the opinion that this, and the increase in registrar appointments, is due in large measure to the failure of Hospital Boards to create additional consultant posts which are needed. In short, these men are in many cases doing work which properly should be done by consultants, and if more consultants were appointed the numbers in the Senior Registrar and Registrar grades could be reduced with benefit to the Service and to the prospects of junior staff aspiring to a consultant career.

Q. 385-387

Question:

Can the Joint Committee provide evidence as to the lack of candidates for registrar and senior registrar appointments (a) in general, (b) as between teaching and non-teaching hospitals, (c) in special hospitals?

Comment:

(8) The following views and figures have been obtained from the Senior Administrative Medical Officers of a number of Hospital Regions:—

NEWCASTLE:

"With regard to the recruitment of Registrars and Senior Registrars I am afraid that we are never overburdened with applications for regional appointments and in certain specialties such as Diagnostic Radiology, Orthopaedic Surgery, Radiotherapy and Pathology, we invariably fail to get any response. The three best specialties in the way of applications are Obstetrics and Gynaecology, General Surgery and General Medicine, but here again when Senior Registrar posts are advertised, we are very fortunate if we get more than two applications.

In this region we work in very close association with the Teaching Hospital and since the inception of the Registrar training scheme, we have held a Joint Committee every month and I think it is true to say that the Teaching Hospital has more or less the same problems as ourselves, but in certain specialties they sometimes receive slightly better applicants, but, of course, there are occasions when even they cannot recruit.

We are trying to overcome the difficulty by advertising appointments where the candidate is offered training not only in the Teaching Hospital, but in some of the larger hospitals in the Region where excellent material is available. Sometimes hospitals in the periphery are more successful in filling their vacancies because the clinical chief is able to contact some of his colleagues in other parts of the country."

SHEFFIELD:**(a) Lack of candidates in Senior Registrar Appointments**

Senior Registrar appointments in this Region come mainly under two headings:

- (i) Reciprocal posts with the teaching hospitals
- (ii) Non-reciprocal posts which generally speaking relate to the regional specialties such as Chest Diseases, Psychiatry, Venereology and Radiotherapy.

(i) Reciprocal posts with the teaching hospitals

These posts cover the specialties of Anaesthetics, E.N.T., General Medicine, General Surgery, Obstetrics and Gynaecology, Pathology and Radiology.

Apart from Radiology, all appointments are filled but it has been observed that the number of applications are fewer and the quality of applicant is lower.

For some time, Senior Registrar appointments in Radiology have been difficult to fill.

(ii) *Non-reciprocal posts*

In Chest Diseases, Orthopaedics and Venereology, all posts are filled but they have been filled for at least two years and therefore the Board has no up to date knowledge of the availability of suitable candidates.

The Board's one Radiotherapy post was last filled 12 months ago but there were only two applicants.

Senior Registrar appointments in Psychiatry have proved very difficult to fill and the Board has one vacancy at present.

(iii) The Regional Hospital Board has no Senior Registrar appointments in Plastic Surgery, Dental Surgery, Ophthalmology, Paediatrics, Neuro-Surgery and Dermatology; any information regarding these specialties should be sought from the Board of Governors, United Sheffield Hospitals.

(b) *Lack of candidates for Registrar Appointments*

Registrar appointments cannot be classified under the headings given. There are no joint appointments between teaching and non-teaching hospitals and generally speaking Registrars are appointed to one hospital although in some cases they provide assistance at a second hospital nearby.

Some Registrar posts seem always difficult to fill and these are analysed generally below. It is not easy to draw any definite conclusion from this analysis; some hospitals and some districts are obviously more attractive than others. Shortage of staff often leads to greater shortage because existing staff are often grossly overworked and leave.

<i>Specialty</i>		<i>Remarks</i>
<i>Chest Diseases</i>	... ..	Three of the Registrar appointments out of a total of nine seem to prove unattractive to applicants.
<i>Obstetrics and Gynaecology</i>		One post out of a total of sixteen seems to prove difficult. The fact that this post is not recognised for the M.R.C.O.G. possibly explains this.
<i>Anaesthetics</i>	... ..	There are fifteen Registrar posts in this specialty and a third of them are difficult to fill.
<i>Neuro-surgery</i>	... ..	There is only one post in the Region and this is rarely filled.
<i>Orthopaedics</i>	... ..	About a third of the fourteen posts in the Region prove difficult to fill.
<i>Orthopaedics and Casualty</i>		There are four Registrar posts where duties are shared between the orthopaedic and casualty departments and three of these are always difficult to fill.
<i>Casualty</i>	... ..	One of the Casualty registrar appointments out of a total of three proves difficult.
<i>Thoracic Surgery</i>	... ..	One of the four posts in the Region does not attract candidates.
<i>Infectious Diseases</i>	... ..	There is only one registrar post in this specialty (others are linked with Chest Diseases) and this always proves difficult.
<i>Psychiatry</i>	... ..	Registrar appointments in Psychiatry constantly cause trouble. If advertisement as Registrar proves unattractive, posts are often advertised in the J.H.M.O. grade.

Apart from the number of applicants, it is interesting to note their nationalities and the following details give:—

(i) The nationalities of Registrars in post, and

(ii) An indication of the nationalities of applicants in Registrar posts.

N.B. During 1957 the Sheffield Regional Hospital Board advertised 201 Registrar posts. Of these, no applications were received in 69 cases. The 388 applicants referred to in Section (ii) of the following table relate to 132 appointments.

Nationality	(i) Registrars in post in Sheffield Region on 15th November, 1957		(ii) Nationalities of applicants for Registrar posts during 1957	
	Number	Percentage	Number	Percentage
Australian	9	6.4	39	10
Bolivian	—	—	1	.3
Burmese	—	—	1	.3
Canadian	—	—	2	.5
Ceylonese	—	—	1	.3
Czechoslovakian	—	—	2	.5
Egyptian	1	.7	11	2.7
Greek	2	1.4	7	1.8
Hungarian	1	.7	2	.5
Indian	35	24.8	171	44.1
Iraqi	—	—	1	.3
Irish	13	9.3	14	3.6
Israeli	1	.7	—	—
Italian	1	.7	1	.3
Jordanian	—	—	1	.3
Maltese	1	.7	2	.5
New Zealand	5	3.6	8	2.1
Palestinian	1	.7	—	—
Pakistani	4	2.8	27	6.9
Persian	—	—	2	.5
Polish	4	2.8	7	1.8
South African	2	1.4	6	1.5
Spanish	1	.7	4	1.0
Turkish	—	—	1	.3
U.K. including Northern Ireland	57	40.5	73	18.8
Ukrainian	1	.7	1	.3
West African	1	.7	—	—
West Indian	1	.7	3	.8
Totals	141	100	388	100

The following more recent analysis of the position in regard to hospital junior medical staff has since been received from the S.A.M.O. of the Sheffield Region:

1. *Nationality of Registrars*

For the purpose of this investigation, the nationalities have been divided into two groups as under:—

Group A
United Kingdom
Australia
Canada
New Zealand
South Africa
America

Group B
All others

(a) *Numbers in post*

On 28th April, 1958, the position in the Sheffield Region was as follows:—

	<i>No. of Registrars in post</i>							
Group A	81
Group B	63*
Total	144

* The 63 registrars in Group B were divided between 14 different nationalities but the majority (45) were Indians or Pakistanis. A large number of those appointed possess temporary registration only.

(b) *Nationalities of applicants for Registrar posts*

The nationalities of applicants for registrar posts in the Sheffield Region during the year ending 31st March, 1958, have been analysed and are as follows:—

	<i>No. of Applicants</i>							
Group A	128
Group B	250*
Total	378

* The 250 applicants in Group B were divided between 21 different nationalities but the majority (201) were Indians or Pakistanis.

Perhaps the figures given in para. 1 (b) indicate the nationality situation better than those in para. 1 (a). The 378 applications analysed relate to 191 registrar posts advertised so that the position was that there were only 128 Group A applicants for 191 posts. A further analysis would undoubtedly reveal:—

- (i) that many of the 128 Group A applicants were for the same posts, i.e., the more attractive ones.
- (ii) where there was only one Group A applicant on the short list, he was nearly always appointed.
- (iii) many posts had no Group A applicants at all.

(c) *Analysis of individual posts*

- (i) In 14 registrar posts, there has not been a Group A incumbent during the 3 years from 1st June, 1955.
- (ii) Only 45 registrar posts out of a total of 113 have been staffed entirely by Group A in the 3 years from 1st June, 1955.

2. *Number of applicants for Registrar posts*

During the twelve months ended 31st March, 1958, the Board advertised a total of 191 Registrar posts; 378 applications were received; no applications at all were received for 66 of the appointments.

3. *Turnover of Registrars*

Other difficulties exist in addition to shortage of medical staff. The turnover of registrars is much greater than it should be as the following figures demonstrate:

Analysis carried out over 3 years from 1st June, 1955 (see note on following page)*

- (a) 315 Registrars have occupied 113 posts.
- (b) 4 Registrar posts (including 3 in General Surgery) have each had 5 different registrars during the three years.
- (c) 16 Registrar posts (including 6 in General Surgery) have each had 4 different registrars during the three years.

(d) 50 registrar posts (including 10 in General Surgery) have each had three different registrars during the three years.

(e) The turnover of registrars in the surgical specialties (particularly general surgery) has been extremely high during the three years in question:—

	<i>No. of posts</i>	<i>No. of Registrars who have occupied the posts</i>
E.N.T.	2	4
Obstetrics and Gynaecology	11	27
Gynaecology	1	4
†Ophthalmology	3	10
†General Surgery	22	75
†Thoracic Surgery	4	13
Casualty	3	8
Orthopaedics	10	30
Orthopaedic/Casualty	2	6
General Surgery/E.N.T.	1	3

† In these specialties, on average registrars remain in post less than a year.

(f) The following analysis of turnover of registrars by specialty is interesting:

	Under 6 months	6 to 12 months	12 to 18 months	18 to 24 months	Over 24 months	Total
Group A	22	79	35	35	22	193
Group B	24	66	18	9	5	122
Total	46	145	53	44	27	315

Those figures show that:—

- (i) 60 per cent. of registrars appointed serve 12 months or less
- (ii) 47 per cent. of Cat. "A" registrars continue beyond their first year.
26 per cent. of Cat. "B" registrars continue beyond their first year.
- (iii) 29½ per cent. of Cat. "A" registrars continue beyond 18 months.
11½ per cent. of Cat. "B" registrars continue beyond 18 months.

* *N.B.* The period 1st June, 1955 to 31st May, 1958 has been analysed. It is possible, during the period of review, for a registrar to terminate his two year appointment say on 30th September, 1955, a registrar to complete a two year tenure 1st October, 1955 to 30th September, 1957 and another registrar to commence 1st October, 1957 and still be in post, i.e., three registrars to go through the post during the 3 year review each completing (or proceeding to complete) a normal 2 year tenure. This possibility was appreciated but it has been ascertained that it only applies to two registrar posts during the review period and therefore the figures quoted are not materially affected.

4. Registrar Vacancies

During the three years from 1st June, 1955, out of 113 posts:—

10	posts	have been vacant for over 6 months
5	"	" " " from 4 to 6 months
20	"	" " " 2 to 4 months
16	"	" " " 1 to 2 months

5. *Pre-registration and S.H.O. vacancies*

There are three types of posts in this Region:—

Intern/S.H.O.—S.H.Os. can only be appointed to these posts if all reasonable attempts to obtain a pre-registration student have failed.

S.H.O./Intern—The Hospital Management Committee can decide whether the post is filled by a S.H.O. or as pre-registration post.

S.H.O.—Must be filled by a S.H.O.—not recognised by the Licensing Authority for pre-registration purposes.

A check was made of the position on 28th April, 1958 and this was as follows:—

					No. on establishment	No. in Post	Vacant
Intern/S.H.O	...	...	...	...	83	42 Interns 32 S.H.Os.	9
S.H.O./Intern	...	...	...	...	34	27 S.H.Os. 4 Interns	3
S.H.O.	...	...	...	...	112	100	12
					229	205	24

The vacancies represent just over 10 per cent. of the total establishment and many Hospital Management Committees, when the review was made, emphasised such points as the difficulties which are constantly experienced in obtaining the most junior staff; posts can only be filled by foreign doctors, etc. Several appointments have been vacant over twelve months, some considerably longer.

6. *Senior Registrar Appointments*

It will be seen from question 4 (b) of Appendix B that the Board consider they can get Senior Registrars of the right quality with the exception of Senior Registrars in Psychiatry, Radiology and Radiotherapy.

The response to all advertisements for Senior Registrars since 1st January, 1954 has been analysed and the following facts are worthy of mention:

(a) *Radiology* ... 1 applicant on 6 occasions
2 applicants on 2 occasions
3 applicants on 1 occasion
—
9 appointments advertised.

(b) *Radiotherapy* ... 1 applicant on 1 occasion
2 applicants on 2 occasions
—
3 appointments advertised.

(c) *Psychiatry* ... 1 applicant on 9 occasions
2 applicants on 3 occasions
7 applicants on 1 occasion
—
13 appointments advertised.

(d) *General Medicine*

7 appointments have been advertised; the most applications ever received has been 7; the most recent advertisement only produced 4 applicants.

(c) *General Surgery*

Whilst the number of applicants might still be regarded as adequate, the following figures show that the number is diminishing:—

				<i>No. of applicants</i>
1 Reciprocal post advertised in 1954	...	...	...	31
1 Reciprocal post advertised in 1955	...	...	...	22
1 Reciprocal post advertised in 1957	...	...	...	16
1 Reciprocal post advertised in 1958	...	...	...	16

NORTH WEST METROPOLITAN REGION:

"I am sending on the enclosed sheets particulars of (a) the senior registrar appointments made during 1957 and, in an attempt to give some comparison, similar appointments made during 1951. Close comparisons cannot be made, however, between the two years for certain reasons. One is that in 1951 there existed no interchange or joint appointments between regional board and teaching hospitals. I think it is clear, however, that the fields were larger in 1951 than they were in 1957. I enclose also (b) a summary of registrar appointments made during 1957 with corresponding information relating to 1951. The registrar establishment has been substantially expanded during the intervening years so the total number of appointments successfully made is not perhaps a fair comparison between the two years. What is revealing is the number of times certain posts have had to be readvertised on account of the poverty of the field and then, in a number of instances, no appointment could eventually be made."

SENIOR REGISTRAR APPOINTMENTS DURING 1957

Group	W/T or P/T	Hospital	Specialty	Whether linked with a Teaching Hospital	No. of applications	No. short- listed	Whether appointment made
Windsor ...	...	King Edward VII, Windsor.	Ophthalmology ...	No	5	2	Yes
Barnet ...	W/T	Clare Hall ...	Thoracic Surgery (Supernumerary).	No	10	4	Yes
	W/T	Group ...	Anaesthetics ...	No	7 (1 withdrew)	4	Yes
Mid Herts	W/T	Herts Child Guidance Hill End ...	Psychiatry ...	No	4	3	Yes
	W/T	...	Psychiatry ...	No	6	5	Yes
Hendon ...	W/T	Edgware General ...	Anaesthetics ...	No	5 (1 withdrew)	3	Yes
	W/T	Edgware General ...	Anaesthetics ...	No	2 (both withdrew)	—	No
	W/T	Edgware General ...	Anaesthetics ...	No	2 (1 withdrew)	1	No
Uxbridge	W/T	Hillingdon ...	Medicine ...	Interchange with Royal Free Hospital	7 (1 withdrew)	5	Yes
St. Barnards	W/T	St. Barnards ...	Psychiatry ...	No	8 (1 withdrew)	4	Yes
Harefield and Northwood.	W/T	Harefield ...	Medicine (Chest Diseases)	No	4 (1 withdrew)	3	Yes
S.W. Middlesex ...	W/T	West Middlesex ...	E.N.T. Surgery ...	No	4 (1 withdrew)	3	Yes (This was a second attempt. Previously advertised unsuccessfully).

SENIOR REGISTRAR APPOINTMENTS DURING 1957—continued

Group	W/T or P/T	Hospital	Specialty	Whether linked with a Teaching Hospital	No. of applications	No. short- listed	Whether appointment made
Central Middlesex	W/T	Central Middlesex and Mount Vernon (Interchange)	Dental Surgery	No	4	4	Yes
	W/T	Central Middlesex	Medicine	No	7	4	Yes
	W/T	Central Middlesex	Surgery	Interchange with Middlesex Hospital	19	7	Yes
	W/T	Central Middlesex	Medicine	Interchange with Middlesex Hospital	8	5	Yes
	W/T	Central Middlesex	Anaesthetics	No	3 (1 withdrew)	2	Yes
	W/T	Central Middlesex	Pathology	No	7	5	Yes
Paddington	W/T	Tavistock Clinic	Psychiatry	No	3	2	Yes
	W/T	Tavistock Clinic	Psychiatry	No	1	1	Yes
Napebury	W/T	Napebury (9/11)	Psychiatry	Joint with Charing Cross Hospital (2/11)	6 (1 withdrew)	4	Yes

The above Table excludes Joint and Interchange Appointments in cases where the Committee was convened and held at the Teaching Hospital. Details are given below:

JOINT AND INTERCHANGE APPOINTMENTS MADE AT TEACHING HOSPITALS

Joint	...	Physical Medicine	...	University College Hospital (6/11)
Interchange	...	Surgery	...	Medical Rehabilitation Centre (5/11)
Joint	...	Psychiatry	...	Middlesex Hospital and Central Middlesex Hospital
Joint	...	Psychiatry	...	Royal Free Hospital (6/11)
Joint	...	Psychiatry	...	Friern Hospital (5/11)
Joint	...	Psychiatry	...	St. Mary's Hospital (7/11)
Joint	...	Psychiatry	...	St. Bernard's Hospital (4/11)
Joint	...	Psychiatry	...	University College Hospital (7/11)
Interchange	...	Surgery	...	Child Guidance Training Centre (4/11)
Interchange	...	Medicine	...	St. Mary's Hospital and N.W.M.R.H.B. Hospitals
Interchange	...	Medicine	...	St. Mary's Hospital and N.W.M.R.H.B. Hospitals
Interchange	...	Orthopaedics	...	St. Mary's Hospital and N.W.M.R.H.B. Hospitals
Interchange	...	Surgery	...	Royal Free Hospital and Haverwood Hospital
Interchange	...	Surgery	...	Royal Free Hospital and Luton and Dunstable Hospital

These were advertised in 1956 without the linkage and no appointments were made.

SENIOR REGISTRAR APPOINTMENTS DURING 1951
(All posts whole-time and none linked with a Teaching Hospital)

Group	Hospital	Specialty	No. of applicants	No. short-listed	Whether appointment made
Friern	Friern	Psychiatry	3	3	Yes
Hendon	Edgware General Edgware General	Anaesthetics Medicine (2 vacancies)	8 4 (1 withdrew)	6 3	Yes Yes (2)
Shenley	Shenley	Psychiatry	10	3	Yes
Staines	Ashford Ashford Ashford Ashford	Anaesthetics Radiology Surgery Surgery	2 6 18 14 (2 withdrew) (1 withdrew)	— 3 5 6	No (Readvertised) Yes Yes Yes
St. Bernard's	St. Bernard's	Psychiatry	4	4	Yes
Uxbridge	Hillingdon	Obstetrics and Gynaecology	13	4	Yes
Harefield and Northwood	Harefield Harefield Harefield	Medicine (Chest Diseases) Medicine (Chest Diseases) Thoracic Surgery	18 (4 withdrew) 15 (1 withdrew) 6 (1 withdrew)	3 6 5	Yes Yes Yes
South West Middlesex	West Middlesex King Edward Memorial West Middlesex West Middlesex West Middlesex	Orthopaedics Surgery Surgery Obstetrics and Gynaecology Anaesthetics	5 16 22 (2 withdrew) 5 (1 withdrew) 4	5 5 4 3 4	Yes Yes Yes Yes Yes

SENIOR REGISTRAR APPOINTMENTS DURING 1951—continued

Group	Hospital	Specialty	No. of applicants	No. short-listed	Whether appointment made
Central Middlesex	Central Middlesex	Radiology	6 (1 withdrew)	3	Yes
	Willesden Chest Clinic	Chest Diseases	12	6	Yes
	Central Middlesex	Orthopaedics	4 (3 withdrew)	1	Yes
Archway	Archway Group Laboratory	Pathology	7 (1 withdrew)	3	Yes
		Medicine and Neurology	4	3	Yes
		Orthopaedics	1	1	Yes
		Medicine...	6	5	Yes
		Pædiatrics	3	2	Yes
		Obstetrics and Gynaecology	7 (2 withdrew)	3	Yes
Northern	Royal Northern	Anaesthetics	6	5	Yes
Paddington	National Temperance	Surgery	7 (2 withdrew)	4	Yes
	Tavistock Clinic	Psychiatry	2	2	Yes
	Plastic Unit, Hill End	Plastic Surgery	11	5	Yes

SUMMARY OF REGISTRAR APPOINTMENTS DURING 1957

(I) *Peripheral Hospitals*

Groups: Bedford, Luton and Hitchin, Mid-Herts, West-Herts, Staines, Windsor.

(a) Appointment made from a field of six or more applicants.

21 Posts filled:

General Medicine ...	10
General Surgery ...	7
Obstetrics and Gynaecology ...	2
Chest Diseases ...	1
Rheumatism ...	1

(b) Appointment made from a field of less than six applicants.

16 Posts filled:

General Surgery ...	4
Anaesthetics ...	3
Casualty ...	2
Orthopaedic ...	1
Geriatrics ...	1
Pathology ...	1
Chest Diseases ...	1
Obstetrics and Gynaecology ...	1
General Medicine ...	1
Paediatrics ...	1

(c) Posts not filled on first advertisement.

Re-advertised once and appointment then made:

St. Albans City ...	Casualty
Watford Peace Memorial ...	Radiology
Staines ...	Gynaecology
Hounslow ...	Chest Diseases
Maidenhead ...	Surgery
Maidenhead ...	Surgery
Upton ...	Anaesthetics

Re-advertised twice and appointment then made:

Watford Chest Clinic ...	Chest Diseases
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Appointment not made:

Luton and Dunstable ...	Anaesthetics
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Re-advertised twice without success.

Luton and Dunstable ...	Paediatrics
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Vacancy filled by senior house-officer.

West-Herts and St. Pauls ...	Anaesthetics (Two Vacancies).
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Re-advertised six times then only one vacancy filled.

Watford Hospitals ...	Obstetrics and Gynaecology. (Locum engaged).
Windsor Chest Clinic ...	Chest Diseases. (Locum engaged).

(II) *Central or Near Central Hospitals*

Groups: Barnet, Hendon, Uxbridge, Harefield and Northwood, S.W. Middlesex, Central Middlesex, Archway, Northern, Paddington and R.L.H.H.

(a) Appointment made from a field of six or more applicants.

62 Posts filled:

General Surgery	19
General Medicine	16
Obstetrics and Gynaecology	10
Paediatrics	4
Psychiatry	3 (1 part time)
Pathology	3
Anaesthetics	2
Radiology	2
Thoracic Surgery	1
Ophthalmology	1
Endocrinology	1

(b) Appointment made from a field of less than six applicants.

39 Posts filled:

Anaesthetics	11
Chest Diseases	7
General Surgery	5
Orthopaedics	2
General Medicine	2
Paediatrics	2
Psychiatry	2 (1 part time)
Ophthalmology	1
Neuro Surgery	1
Pathology	1
Obstetrics and Gynaecology	1
Medicine (Hom.)	1 (part time)
Neurology	1
E.N.T.	1
Casualty	1

(c) Posts not filled on first advertisement:

Re-advertised once and appointment then made:

Hendon Isolation	Medicine (I.D.)
Edgware General and Bushey	Obstetrics
Harefield	Chest Medicine
Harefield	Chest Medicine
Mount Vernon	Radiology
South Middlesex	Infectious Diseases
Central Middlesex	Anaesthetics

Re-advertised twice and appointment then made:

Uxbridge Chest Clinic	Chest Diseases
Finchley Chest Clinic	Chest Diseases

Re-advertised three times and appointment then made:

Colindale	Chest Medicine
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Re-advertised five times and appointment then made:

Royal Northern	Radiology
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No appointment made:

Edgware General	Anaesthetics
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One vacancy re-advertised four times, and later two vacancies re-advertised once.

Colindale	Surgery
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Re-advertised once—no applicants either time.

Hillingdon, St. Johns etc.	Geriatrics
Re-advertised once.	(Second re-advertisement in 1958 successful).				
Royal Northern	...	...	...	...	Orthopaedic
Re-advertised twice.					
Royal Northern	...	...	...	...	Casualty
Unsuccessful advert. in 1957.	Re-advertised twice in 1958 before appointment was made.				

(II) *Psychiatric Registrars at Mental Hospitals*

9 Posts filled:

(Four cases where the field of applicants were six or more).

REGISTRAR APPOINTMENTS IN 1951

(I) *Peripheral Hospitals*

Groups: Bedford, Luton and Hitchin, Windsor, Mid-Herts, West-Herts, Staines.

(a) Appointment made from a field of six or more applicants.

3 Posts filled:

Anaesthetics	...	...	...	...	...	1
Rheumatism	...	...	...	...	...	1
Medicine	...	...	...	...	...	1

(b) Appointment made from a field of less than six applicants.

11 Posts filled:

Surgery	...	...	...	...	...	2
Medicine	...	...	...	...	...	2
Orthopaedics	...	...	...	...	...	2
Dental	...	...	...	...	...	1
Paediatrics	...	...	...	...	...	1
Obstetrics and Gynaecology	...	...	...	...	...	1
Chest Diseases	...	...	...	...	...	1
Pathology	...	...	...	...	...	1

(c) *No appointment made:*

Orthopaedics—Heatherwood.

One applicant only—appointed as locum for 3 months, and then a report from the consultant.

Chest Diseases—Windsor C. Cl.

Two applicants: one seen, post to be re-advertised.

(II) *Central or Near Central Hospitals*

Groups: Barnet, Hendon, Uxbridge, Harefield and Northwood, Central Middlesex, Archway, Northern, Paddington and R.L.H.H.

(a) Appointment made from a field of six or more applicants.

25 Posts filled:

Medicine	...	...	...	...	...	9
Obstetrics and Gynaecology	...	...	...	...	...	7
Anaesthetics	...	...	...	...	...	3
Psychiatry	...	...	...	...	...	3
Surgery	...	...	...	...	...	2
Radiology	...	...	...	...	...	1

(b) Appointment made from a field of less than six applicants.

32 Posts filled:

Medicine ...	...	...	...	...	...	...	6
Anaesthetics ...	...	...	...	...	...	...	3
E.N.T. ...	...	...	...	...	...	...	3
Radiology ...	...	...	...	...	...	...	3
Chest Diseases ...	...	...	...	...	...	...	3
Paediatrics ...	...	...	...	...	...	...	3
Psychiatry ...	...	...	...	...	...	...	3 (2 part time)
Obstetrics and Gynaecology ...	...	...	...	...	...	...	2
Thoracic Surgery ...	...	...	...	...	...	...	2
Casualty ...	...	...	...	...	...	...	1
Pathology ...	...	...	...	...	...	...	1
Phys. Med. ...	...	...	...	...	...	...	1
Orthopaedics ...	...	...	...	...	...	...	1

(c) No cases where no appointment was made.

(III) *Psychiatric Registrars in Mental Hospitals*

7 Posts filled:

(One case where the field of applicants was six or more.)

SOUTH EAST METROPOLITAN REGION
SENIOR REGISTRARS—SUMMARY OF APPOINTMENTS ADVERTISED, ETC.

Year	CENTRAL HOSPITALS			PERIPHERAL HOSPITALS			SPECIAL HOSPITALS		
	No. of posts advertised	No. of applicants	No. of occasions no appointment made	No. of posts advertised	No. of applicants	No. of occasions no appointment made	No. of posts advertised	No. of applicants	No. of occasions no appointment made
1955 ...	7	49	1	—	— (see note 1)	—	1	12	—
1956 ...	7	22	5	—	—	—	6	18	5
1957 ...	6	24	1	—	—	—	2	1	1

Notes:

1. The majority of the Senior Registrar appointments in Central Hospitals are joint appointments made with teaching hospitals, under the special interchange scheme. The teaching hospitals (Guy's, King's College and Maudsley) make arrangements for the appointments.
2. The appointments not made were for Senior Registrar (Psychiatry) posts in Regional hospitals.

One appointment of Senior Registrar in Thoracic Surgery shown under special unit column

REGISTRARS—SUMMARY OF APPOINTMENTS

Year	GENERAL TOTAL			CENTRAL HOSPITALS			PERIPHERAL HOSPITALS			SPECIAL HOSPITALS OR UNITS		
	No. of posts advertised	No. of applicants	No. of occasions no appointment made	No. of posts advertised	No. of applicants	No. of occasions no appointment made	No. of posts advertised	No. of applicants	No. of occasions no appointment made	No. of posts advertised	No. of applicants	No. of occasions no appointment made
1955 ...	73	265	25	34	141	11	21	93	6	18	31	8
1956 ...	87	246	35	25	109	7	44	113	20	18	24	8
1957 ...	96	307	29	30	127	7	45	136	16	21	44	6

SOUTH WESTERN:

"It is becoming more and more difficult to make suitable appointments in the Registrar and Senior Registrar grades. In the Registrar grade it sometimes happens that advertisements produce no applicant at all and, when advertisements do produce candidates, not infrequently they are unsuitable for appointment. Thus, compared with, say, five years ago, the applicants are fewer in number and, in some specialties, their quality is not as good as it was. Some excellent candidates from the Commonwealth seek appointments as Surgical Registrars and we are glad to give them every possible help.

The teaching hospital has the advantage over the non-teaching hospital because many Registrars and Senior Registrars have come to believe that they are unlikely ultimately to be appointed Consultants unless they have been trained in teaching hospitals. There is very little difference between the response which we receive to advertisements for trainee posts in central and peripheral hospitals, and, so far as special departments are concerned, the position is deplorable."

WELSH:

"The lack of candidates for registrar and senior registrar appointments has become more noticeable in recent years, and nowadays it is particularly difficult to recruit registrars for appointments in outlying hospitals. As you have placed these registrar posts in the various categories, I will deal with each in turn.

- (a) As I have already stated the overall number of applicants competing for these trainee appointments has become less and less until it is quite a common occurrence to have to advertise an appointment on several occasions before we are successful in appointing a suitable candidate.
- (b) The joint appointments which exist between a teaching and non-teaching hospital continue to yield one or two very good candidates, but, here again, there is considerable evidence of a reduction in the number of candidates competing for these appointments.
- (c) As one would expect the central hospital has a considerable advantage over the peripheral hospital and our difficulties in filling registrar posts are inevitably increased when the vacancy exists at one of the outlying hospitals, which can well be a great distance from any main centre or the teaching hospitals which afford facilities for registrars at some of the regional hospitals in the immediate vicinity.
- (d) There are certain recruitment difficulties which affect registrar appointments at special hospitals, but for the most part I would say that in our experience the functions of these hospitals are still sufficient to attract a candidate of the required standard."

LIVERPOOL:

"I would say that, in general, there is no lack of applicants for Senior Registrar posts except perhaps in certain specialties, such as Psychiatry and Radiotherapy, and I would qualify this statement by saying that, especially in Psychiatry, the applications we do receive are from doctors who do not really have sufficient experience in the specialty to qualify for appointment to a Senior Registrar post.

It is quite clear that there is a shortage of suitable candidates for Registrar posts, especially in E.N.T., Orthopaedic Surgery, Thoracic Medicine, Dentistry, Pathology and Radiotherapy. I feel that it would generally be found that the Teaching Hospitals will always have more applicants than the non-teaching hospitals and I am quite sure that this applies in the Liverpool region. The same situation does exist as between central and peripheral hospitals in Regional Board Hospitals. It is always difficult for us to obtain suitable applicants in most specialties in the peripheral areas.

To emphasise the lack of suitable candidates for the Regional Hospitals I would quote one instance where we advertised for a Registrar in General Surgery with the Professorial Unit at a central Regional Hospital and received 11 applications. All the applicants were of foreign nationality, 10 applications being received from Indians and one from an Austrian.

With regard to special hospitals, for example, Liverpool Radium Institute and the Sanatoria, there is an inadequate supply of candidates. In Radiotherapy the candidates are invariably Indians and we have, on a number of occasions, been forced to fill the one Senior Registrar post in Radiotherapy in the Registrar grade as we received no response to our advertisement. The reason for our difficulty in obtaining Registrars in Thoracic Medicine for Sanatoria is, I am sure, obvious."

MANCHESTER:

"In general, there is a lack of candidates for registrar posts. Most registrar posts in this region are filled, although 30 per cent. of the holders are not of U.K. origin. The general impression amongst consultants seems to be that in quality and qualifications the registrar to-day is inferior to the registrar of five years ago or more.

As far as senior registrars are concerned, there is no doubt that the number of applicants for these posts is much less than it was five or six years ago. The qualifications and calibre of the applicants is also less satisfactory. It is very difficult to get applicants at all for posts in psychiatry, radiology, E.N.T. surgery, orthopaedic surgery and the specialised branches of surgery. Sometimes a senior registrar post has to be advertised several times before a suitable candidate is appointed. I am told that this difficulty in obtaining senior registrars is now beginning to affect the teaching hospitals, in spite of the fact that in this region there is a rotation scheme which works fairly satisfactorily. The latest specialty where marked difficulty has been experienced is in general medicine.

I cannot speak of the difference between central hospitals and peripheral hospitals because all the hospitals in this region which have senior registrar posts on their establishment are central hospitals. Furthermore, we have very few senior registrars at special hospitals."

WESTERN REGION OF SCOTLAND:

Registrar Appointments

In 1953	...	65 Registrar posts were advertised
		Of these 43 were first advertisements
		12 were second advertisements
		10 were third or subsequent advertisements
In 1957	...	151 Registrar posts were advertised
		Of these 62 were first advertisements
		17 were second advertisements
		72 were third or subsequent advertisements (up to 12th)

Quality of applicants for posts:

Surgery	...	1952	...	Teaching Hospital	15 applicants (5 with a Fellowship)
		1953	...	Peripheral Hospital	1 applicant (withdrew)
		1953	...	Teaching Hospital	5 applicants (2 with Fellowship)
		1954	...	Peripheral Hospital	2 applicants (none with Fellowship)
		1955	...	Teaching Hospital	7 applicants (1 with Fellowship)
		1957	...	Teaching Hospital	4 applicants (2 with Fellowship; 1 already a Reg.)
		1957	...	Peripheral Hospital	4 applicants (3 foreign applicants)
		1957	...	Teaching Hospital	Readvertised because of lack of suitable applicants
		1957	...	Peripheral Hospital	Advertised four times without success

					<i>Number of Applicants</i>	
					<i>Teaching Hospital</i>	<i>Peripheral Hospital</i>
Medicine ...	1952	...	...	...	11 (5 with H.Q.)	—
	1953	...	...	...	—	1
	1954	...	...	...	9	—
	1955	...	...	...	—	3
	1957	...	...	...	5 (2 with H.Q.)	2
Anaesthetics ...	1952	...	...	...	5	—
	1954	...	...	...	4	—
	1957	...	...	...	1	—
E.N.T. Surgery	1952	...	...	...	2	—
	1953	...	...	...	3	—
	1954	...	...	...	1	—
	1955	...	...	...	2	—
	1957	...	...	...	1 after repeated advertisement	—
Obstetrics and Gynaecology	1952	...	...	...	10	—
	1954	...	...	...	—	2
	1955	...	...	...	9	2
	1957	...	...	...	3	Non-teaching 3
Ophthalmology	1953	...	...	...	2	—
	1954	...	...	...	3	—
	1957	...	...	...	2	—
Surgery ...	1952	...	...	...	15	—
	1953	...	...	...	5	1
	1954	...	...	...	7	2
	1955	...	...	...	7	—
	1957	...	...	...	4 (2 posts were readvertised)	4

Senior Registrars

Surgery ...	1953	...	...	...	22	14
	1956	...	...	...	8	8
	1957	...	...	...	9	—
Medicine ...	1952	...	...	...	—	15
	1953	...	...	...	10	—
	1955	...	...	...	6	3
	1956	...	...	...	10	—
	1957	...	...	...	6	1 (unsuitable)
Anaesthetics ...	1952	...	...	...	4	2
	1954	...	...	...	7	3
	1956	...	...	...	4	5
	1957	...	...	...	5	—
E.N.T. Surgery	1952	...	...	...	4	—
	1953	...	...	...	7	—
	1954	...	...	...	4	—
	1955	...	...	...	2	—
	1956	...	...	...	1	—

					<i>Number of Applicants</i>	
					<i>Teaching Hospital</i>	<i>Peripheral Hospital</i>
Obstetrics and Gynaecology	1951	...	...	...	12	—
	1952	...	...	...	11	10
	1955	...	...	...	—	4
	1956	...	...	...	11	—
	1957	...	...	...	6	—
Ophthalmology	1952	...	...	...	4	—
	1953	...	...	...	5	—
	1955	...	...	...	3	—
	1956	...	...	...	3	—
	1957	...	...	...	2	—

Posts which have proved difficult to fill:

1. Reg. E.N.T.	...	Royal Inf. (T)	...	advised	12 times to date
2. Reg. Surg./Obst./Gyn.	...	Greenock Area	...	"	10 " "
3. Reg. Pathology	...	Victoria Inf. (T)	...	"	11 " "
4. Reg. Pathology	...	Dumfries	...	"	8 " "
5. Reg. Surgery	...	R.A.I. Paisley	...	"	9 " "
6. Reg. Pathology	...	Maternity (T)	...	"	7 " "
7. Reg. Surgery	...	P. Glasgow	...	"	9 " "
8. Reg. Psychiatry	...	Riccartbar	...	"	6 " "
9. Reg. Radiodiagnosis	...	Victoria (T)	...	"	6 " "
10. Reg. Psychiatry	...	Bellsdyke/R.S.N.I.	...	"	5 " to date
11. Reg. Surgery	...	Law	...	"	5 " "
12. Reg. E.N.T.	...	Stobhill	...	"	5 " "
1. Sen. Reg. Radiotherapy	...	Western Inf. (T)	...	"	13 " "
2. Sen. Reg. Ophthalmology	...	Ophthalmic Inst.	...	"	4 " "
3. Sen. Reg. Ophthalmology	...	Eye Inf. (T)	...	"	5 " "
4. Sen. Reg. Medicine	...	Hairmyres	...	"	3 " "
5. Sen. Reg. Pathology	...	Southern General (T)	...	"	4 " "
6. Sen. Reg. Plastic Surgery	...	Royal/Western (T)	...	"	4 " "

(T) = Teaching Hospital

Senior Registrars

In 1953 ... 31 posts were advertised
Of these 1 was a readvertisement

In 1957 ... 64 posts were advertised
Of these 38 were first advertisements
7 were second advertisements
19 were third or subsequent advertisements

The following comments have also been received from consultants on the staff of London teaching hospitals:—

Dr. Reginald Kelly:

"Thank you for your letter of 9th January. The question of the difficulty in obtaining Senior Registrars and Registrars is a matter in which my experience has been that what difficulty does exist is mainly concerned with the non-teaching hospitals. In the two teaching hospitals to which I am attached we have had no difficulty in recent years in finding adequate applicants for Registrar appointments in General Medicine and General Surgery. We have always had a choice of several applicants, all of whom have their Membership, and I do not know of any examples in recent years of worthwhile applicants failing to apply for Registrar posts because of financial difficulties. In the special departments of St. Thomas' Hospital, however, it has become plain in recent years that a decreasing number

of doctors are prepared to apply for Registrar posts. In the Children's Department, for instance, recently we had only three applicants for a Senior Registrar appointment and we were unable to make an appointment because we felt that none of the three applicants were of sufficient merit. In the Neurological Department we have had no difficulty but that is because we encourage doctors to apply for our own Registrar post who are anxious to learn some Neurology before taking up General Medicine and only about one in three or four Registrars intends to take up Neurology as a career. At the Maida Vale Hospital, since I have been on the Staff there, we have always had a considerable number of good applicants, both for the Resident and the Registrar appointments, middle and Senior Registrars, and on those occasions when we have appointed overseas doctors, it was because we judged them to be the better applicant, rather than because there was any shortage of well trained and experienced British doctors applying for the jobs.

In non-teaching hospitals the position is entirely different. In the last eight years I have been connected with three large non-teaching hospitals, Queen Mary's Hospital for the East End, the Prince of Wales' Hospital at Stamford Hill and Mount Vernon Hospital at Northwood. In the first two of these three hospitals, the only applicants for the Registrar posts who have the Membership have been visiting doctors from the Dominion countries. It has become plain that any doctors who have any future in Consultant medicine refuse to apply for these appointments at non-teaching hospitals because experience has taught them that in spite of the special experience that they gain at these hospitals it is extremely difficult for them to get back to their teaching hospital in a Registrar or Senior Registrar appointment if they have spent a considerable period in a non-teaching hospital. Another disadvantage of working in non-teaching hospitals and of which these doctors are aware is the fact that there is a very large volume of routine work for them to do, far greater than they are called upon to do at a teaching hospital. It occupies a very large part of their ordinary working week and leaves little time for personal study, for attending post graduate courses or lectures, or for carrying out any original work. At Mount Vernon Hospital we have had rather less difficulty in obtaining good applicants for the Medical Registrar appointment, but this is purely and simply because Mount Vernon Hospital is in many ways an annexe to the Middlesex Hospital. A large number of the staff are on the Staff of the Middlesex Hospital and the applicants for the posts always come from the Middlesex Hospital with the certain knowledge that they stand a very good chance of being able to return to the Middlesex Hospital for their more senior appointments. I believe, myself, that one of the difficulties in filling these appointments at non-teaching hospitals is due to the fact that when the National Health Service came into being, the majority of these Registrar posts were down-graded and in the years immediately before the War at both the Prince of Wales' Hospital and Queen Mary's Hospital, it had been the custom for the Medical Registrar to be a doctor who had completed his training for Consultant appointments, who already had had his senior qualifications for some years and who was, in fact, waiting for a Consultant appointment. They were able to hold these jobs for a number of years and almost invariably left them for Consultant appointments. Dr. Carmichael Young, for instance, who is one of the Physicians at St. Mary's Hospital was Registrar at the Prince of Wales' Hospital until he received that appointment. It is undeniably an attraction to the candidate, who might apply for the appointment at a non-teaching hospital, if one or more of the Physicians are attached to a teaching hospital. Consequently those at non-teaching hospitals whose staff are concerned only with non-teaching hospitals have far greater difficulty than Mount Vernon Hospital has at the present moment or the Prince of Wales' Hospital had until I resigned from the Staff of that hospital a few weeks ago.

A point that I would like to make but not, perhaps, connected directly with our difficulties at the Maida Vale Hospital in appointing Registrars so much as dealing with the difficulties that we make for the applicants. Last week we were appointing an ordinary Registrar in Neurosurgery, jointly with the Maida Vale Hospital and the Middlesex. We had three excellent candidates with previous experience in Neurosurgery and with their Fellowships. Mr. Logue considered, quite obviously reasonably, that the successful applicant must have a car, as by the nature of his

work he would be expected to travel quickly not only from one hospital to the other, but also when called out, as he is likely to be called out several times a week, during the night. The successful applicant did not, in fact, have a car, and so it was pointed out to him that we would be unable to offer him the job unless he was prepared to get himself a car. This, in fact, he agreed to do, but I felt that it was quite iniquitous that we should find ourselves in the position of having to demand that a young man should buy a car and run it at his own expense on the comparatively low salary he was being offered for the job when we are, at the same time, not in a position to offer him the ordinary mileage allowance for daily use of the car that he would receive were he a part-time employee of the Service. He is a married man with two children and this requirement on our part that he should get a car is obviously going to place him in considerable financial difficulty unless he has a private income. He accepted this condition of service quite obviously because he wanted the job very badly, but it is plain that a doctor who is entirely dependant upon his salary would have found it quite impossible to accept the job under those circumstances."

"As you know I am on the staff of St. Thomas' Hospital and we have in recent years received at least two requests from the Regional Hospital Boards which in themselves mirrored the difficulties that the Regional Hospitals have in filling their Senior Registrar posts with suitable applicants. We have, as many teaching hospitals in London have at the present moment, an arrangement with Southampton whereby we make a joint appointment of a Senior Medical Registrar with the Southampton hospitals, which results in each of our four Senior Registrars spending one of their four years working in a Southampton Hospital Group. We were specifically asked to do this because of the difficulties they have of getting suitable candidates. We have recently been asked by the East Anglian Regional Board whether we would be prepared to make the same arrangement with them, or an arrangement which is similar. The arrangement that they are asking for is that a Senior Registrar appointed to them should be allowed to be seconded for one year to work at St. Thomas' Hospital, because they feel that by doing this they may make their own Senior Registrar appointment more attractive and, therefore, perhaps get better applicants. It is not possible, obviously, for me to anticipate the decisions of our own Joint Medical Committee at St. Thomas' Hospital but it seems to me likely that at least many of my colleagues will be unwilling to continue the present arrangement we have with Portsmouth and Southampton and if that is so, it is clear that these Provincial Regional Hospital Boards will have greater difficulty in filling their appointments."

Dr. J. Hamilton Paterson:

"I hope the following information which I have culled from our records here will be of help to you in connection with the Royal Commission.

During the last three years there have been 12 appointments to the resident staff of registrar and senior registrar grade (the resident medical officer is a senior registrar grade). The average number of applicants for these posts fell from six in 1955 to three last year. Six of the successful candidates were from the United Kingdom—six were from Overseas. Over the same period there were seven vacancies for senior registrar appointments to the Out-patient department. On two occasions no appointment was made and it is of note that last year there was only one applicant on one occasion and none at all on the other when such a vacancy arose. Similarly, four registrar grade appointments in the Out-patient department have been advertised over the same period, although on one occasion the post was not filled through lack of a suitable applicant. All the registrars who have been appointed to the Out-patient department have come from the United Kingdom.

In short, we have not as yet experienced much difficulty in obtaining suitable resident house physicians, although the number of applicants has steadily fallen in recent years. In the Out-patient department, however, we have latterly had very considerable difficulty in filling our vacant registrar and senior registrar posts. I should add that this information does not include surgical appointments. There are never many candidates for these posts."

D. Q. 388

Question:

Will the Joint Committee comment on any differences in staffing between teaching hospitals and non-teaching hospitals, especially peripheral hospitals?

Comment:

(9) In general, teaching hospitals are more heavily staffed than non-teaching hospitals both in the senior and junior grades of medical staff. This is necessary to meet the needs of teaching and research in addition to the care and treatment of patients. In addition it is the normal practice in the clinical departments of teaching hospitals for consultants to work in "firms"; i.e. a senior and junior consultant (both of full consultant status) dividing the consultant work between them and sharing junior staff. This system is not so common in non-teaching hospitals, where consultants tend to work independently.

(10) The majority of senior registrars are employed in teaching hospitals, where better and, in some instances, the only facilities for training exist. In many cases there are arrangements for these senior registrars to spend part of their time in non-teaching hospitals, but a great many non-teaching hospitals, particularly the smaller ones, do not have senior registrars.

(11) As will be seen from the comment on Question 3 above, there is usually more difficulty in filling junior vacancies in Regional Hospitals than in teaching hospitals. It is undoubtedly true that appointments in teaching hospitals have always proved attractive because of the great advantage which a teaching hospital training confers on the aspirant for a consultant post. At the present time, however, registrars and senior registrars who hope to make their career in consultant practice tend actively to avoid non-teaching hospital appointments in the belief that such appointments will handicap them in the competitive struggle for promotion.

(12) Another reason for the shortage of junior staff in non-teaching hospitals is that hospital experience is no longer regarded as increasing a young doctor's prospects of entering general practice.

(13) Some outlying hospitals were able in past years to attract junior staff by offering them a higher rate of remuneration than did the teaching and larger non-teaching hospitals. Except to a very limited extent this is not possible under the Health Service.

(14) The inadequate staffing of many non-teaching and peripheral hospitals makes cover during periods of annual leave more difficult to arrange and throws a heavy burden on the medical staff in times of emergency.

E. Q. 431-432

Question:

There is evidence that the ratio of whole-time and part-time consultants is changing. Is this good for the Health Service? Is there a minimum below which the whole-time establishment should not fall? What, in the opinion of the Joint Committee, is the appropriate ratio between whole-time and part-time consultants?

Comment:

(15) There would appear to be no evidence that any substantial change is taking place in the ratio between the numbers of whole-time and part-time consultants. The following figures for England and Wales provided by the Ministry some years ago show that in the early years of the Health Service there was a movement towards whole-time employment.

	Total No. of Consultants	Whole- time	Part- time	Percentage of whole-time to Total
31st December, 1949	5,189	1,309	3,880	24.4
31st December, 1950	5,649	1,491	4,158	26.4
31st December, 1951	5,882	1,650	4,232	28.1
31st December, 1952	6,247	1,780	4,467	28.5

(16) Figures obtained from four English Regions in respect of the years 1955-57 show a slight movement towards part-time employment:

Newcastle, Sheffield, Manchester and S.E. Metropolitan Regions

				Total No. of Consultants	Whole- time	Part- time	Percentage of whole-time to Total
1955	...	...	...	1,804	461	1,343	25.5
1956	...	...	...	1,828	447	1,381	24.4
1957	...	...	...	1,868	453	1,415	24.2

(17) In these four Regions 53 consultants changed from a whole-time to a maximum part-time basis in the three years 1955-57, and 2 maximum part-time consultants changed to a whole-time basis. In this period the total number of part-time appointments increased by 72, and the number of whole-time appointments dropped by 8. Allowing for these transfers from whole-time to part-time and *vice versa*, this means that 43 new whole-time posts were created, as against 21 part-time.

(18) The Joint Committee does not consider, however, that fluctuations in numbers of whole-time and part-time consultants of the kind illustrated above have any special significance. Certainly it could not accept the argument that it would be contrary to the good of the Health Service and the community to allow the number of whole-time consultants to fall below a certain level. As the Committee has previously stated, *all* consultants have a continuing responsibility for the patients under their care, and it would be completely false to assume that the whole-time consultant is indispensable. The great majority of part-time consultants are engaged for the maximum of nine sessions, and in practice it would be impossible to distinguish between the responsibilities in the Health Service of whole-time and maximum part-time consultants.

(19) At the outset of their careers a proportion of young consultants accept whole-time appointments as bringing a certain element of financial security, but when they become established in the area they may prefer the independence of private practice. This is particularly true in the main clinical branches, as opposed to branches such as, say, psychiatry or chest diseases, where there is a tradition of whole-time service.

(20) It should be pointed out, however, that when a whole-time consultant transfers to a maximum part-time basis he almost invariably gives his employing authority an undertaking to continue to fulfil all the duties of his appointment as hitherto, so that the Health Service does not lose by the transfer, but on the contrary makes a financial saving.

F. Q. 494

The Consultant Spens Committee recommended the present system of merit awards when there were 1,600 consultants. There are now 7,000. Does this alter the validity of their recommendation?

Comment:

(21) The figure of 1,600 consultants referred to by the Royal Commission is presumably the number of consultants from whom Professor Bradford Hill obtained information when he made his enquiry into the pre-war earnings of consultants for the benefit of the Spens Committee.

(22) A classification of the profession carried out for the Central Medical War Committee in March, 1940, however, gave the total number of consultants and specialists at that time as 4,601. This figure includes those in Northern Ireland (not more than 100-150), but probably excludes a number of university teachers and research workers who were also working in hospitals as consultants.

(23) In the view of the Joint Committee there is nothing in the Spens Report to suggest that in putting forward its recommendations regarding distinction awards the Spens Committee was at all influenced by, or concerned with, the actual number of consultants at that time. On the contrary, the Spens Committee was concerned solely with the task of evolving a satisfactory system of remuneration for consultants, of whom it said: "We are satisfied that there is far greater diversity of ability and effort among specialists than admits of remuneration by some simple scale applicable to all. If the recruitment

and status of specialist practice are to be maintained, specialists must be able to feel that more than ordinary ability and effort receive an adequate reward. Moreover, a reward which would be appropriate when these exist would be extravagant when they do not. In consequence we are clear that any satisfactory system of remuneration must involve differentiation dependent on professional distinction." (Paragraph 13.)

(24) From this and the succeeding paragraphs of its report the Spens Committee made it clear that in its view the remuneration of a consultant should rest *primarily* upon an assessment of individual ability, the main purpose of the basic salary scale being to reward the younger consultant for the progressive increase in professional skill and experience to be expected during the initial years of his appointment.

(25) To ensure a satisfactory spread of incomes in the higher age group, and to reward the younger consultant of outstanding ability, the Spens Committee recommended 3 distinction awards to be granted to fixed percentages of the total number of eligible consultants.

(26) The Committee believes that the considerations which led the Spens Committee to make this recommendation are still valid, and that there would be no justification for departing from it because of changes in the total number of consultants.

G. Q. 524-529

Question:

Can the Joint Committee provide evidence as to the effect of the Health Service on private consulting practices? What is to be inferred from the growth of the Provident schemes? Can such schemes provide figures which could throw a light on this point?

Comment:

(27) Although the Joint Committee has no figures showing the effect of the Health Service on private consulting practice earnings, there can be no doubt that the effect has been a disastrous one. This is evidenced by the reduction in the number of hospital private beds since 1948, and by the closure of many private nursing homes. For example, in Newcastle, before the Health Service there were 161 nursing home beds available for the use of the consultants. There are now 61 available to a substantially increased number of consultants. At December, 1955, the number of private beds in N.H.S. hospitals throughout Great Britain was 6,409—i.e., 1.2 per cent. of the total of 548,045 hospital beds.

(28) The amount of private consulting practice still available varies from area to area, from specialty to specialty, and from consultant to consultant. In central London the decline may not be so marked as in most other places, but this is in no small measure due to the numbers of visitors from other countries seeking advice and treatment in the Metropolis.

(29) In paediatrics private practice has severely declined. This is thought to be due to the improved amenities of children's hospital beds and to the heavy expenses incurred by parents in the maintenance and education of their children. In specialties such as pathology and radiology the fall in private practice has been most marked.

(30) One factor influencing the amount of private practice, to which the Committee has already referred, is the high cost (and in some cases the poor quality) of the private accommodation in hospitals.

(31) The cost of providing hospital treatment with all its modern procedures and aids has become so high that were it not for the Hospital Provident Schemes none but the very wealthy could now contemplate private treatment at all.

(32) The popularity of the Provident Schemes since 1948 indicates that there is a substantial section of the community who would wish, in the event of hospital treatment becoming necessary, to arrange for it privately. The benefits provided by the Provident Schemes, however, do not normally cover the total expenses which the patient has to meet in the way of hospital bed charges and professional fees. This is significant because the majority of members of the Provident Schemes are people of modest means. It is understood that the organisers of the Provident Schemes are already concerned at the growing gap between their benefits and the cost of treatment. A substantial increase

in the contribution rates of Provident Schemes would almost certainly result in a sharp drop in membership. Further increases in hospital bed charges or professional fees would similarly have a drastic effect on private consulting practice. In other words, the continuance of private practice depends almost entirely on its cost being maintained at a reasonably low level. It would therefore be indeed rash to assume from the growth in the membership of Provident Schemes in recent years that a resurgence of private consulting practice is taking place, or that the earnings from private practice are likely in the future to become a significant part of the total remuneration of the general body of consultants.

Examination of Witnesses

MR. T. HOLMES SELLORS (*Chairman*)

SIR HAROLD BOLDERO

DR. J. D. S. CAMERON

DR. T. ROWLAND HILL

MR. J. P. COCKER

DR. D. P. STEVENSON (*Secretary*)

on behalf of the Joint Consultants' Committee

Called and Examined

5032. *Chairman*: I think you have all appeared before us on a previous occasion, Mr. Holmes Sellors, so I do not need to go through the preliminaries in explaining what may happen.—*Mr. Holmes Sellors*: That is so. I think everyone understands. We regret the loss of Sir Russell Brain from our Committee; we are very inadequate to take his place.

Chairman: We have already had a long discussion with you as far back as the 18th December last on your preliminary memorandum of evidence, and that is why some things in your subsequent evidence we may wish to go over only very slightly. In addition there are some things which have been discussed with other witnesses; your later memoranda cover to some extent the same ground and it may not be necessary to go into them in detail. We have received three memoranda from you apart from your preliminary memorandum and we would wish to refer to all three. It might perhaps help you if I just ran through all four. Your preliminary memorandum was the one that you put in in response to our request, as a general statement about the organisation of the profession and the background of the dispute with the Government. That was the basis of the oral evidence we had last December. The second memorandum [*beginning on page 1082*] is your description of the functions and responsibilities of the grades below Consultant; that is the

one we would like to deal with quickly and first. That was submitted in September, 1957, in response to a request by us to Sir Russell Brain to give us a note on the subject. I think it is largely factual and it was not the subject of elaboration in December last, although we had got it before then. It is primarily for the purpose of getting it on the record that we would just like to have a word or two about it.

The third memorandum [*beginning on page 1085*] is your main submission in response to the list of questions that we sent to a lot of medical and dental organisations. It is with that we shall be mainly dealing today. The fourth memorandum [*beginning on page 1109*] is what you call a "Supplementary Memorandum of Evidence" which you prepared in answer to questions that we raised during oral evidence in December last.

5033. *Sir David Hughes Parry*: May I refer you to paragraph 8 on page 1083? You say, "Consultant grading is a personal one dependent upon the possession of appropriate qualifications, training and ability". But in paragraph 44 on page 1092 you have used the word "Consultant" with respect to status and with respect to quality "... in an S.H.M.O. post doing work of consultant quality and responsibility." I wonder whether you would like to comment on that? First you emphasise that a consultant grading is something very personal; then you deal with a post that is a consultant

post and a status that is a consultant status.—I do not think there should be any particular difficulty in dealing with that. This is used in the connotation of the Senior Hospital Medical Officer. What we are saying in paragraph 44 is that an S.H.M.O. who is of consultant quality by virtue of his experience and qualifications and so on, ought to be treated as a consultant, particularly when he is doing work of that character. As you will understand, there is a great deal of difficulty in applying an exact definition to "consultant". When we were defining the S.H.M.O. grade we went to a great deal of trouble to limit people in that grade to certain fields of activities. A number of those S.H.M.O.'s are doing work that we find is virtually that of a pure consultant character. We feel that many of those people ought to be treated as consultants.

5034. That is all I want to ask on that, just to clarify the position, because you have emphasised, you will agree, the personal nature of the status of consultant. We now come to your main memorandum. I would refer to paragraph 2 on page 1086 where you name seven bodies represented on your Committee. What I would like to know is whether you regard all consultants as within the purview of those bodies or are there any consultants outside them?—I cannot think of any consultants who are not represented once or even twice by those bodies.

5035. *Chairman*: There is no specialist or consultant who would not be a member of one of these?—Not in the medical profession; I cannot think of any.

5036. Would that apply to the first six of those bodies, leaving out the seventh for the moment?—Well, it is possible that there may be some people who have solely University qualifications and have not a qualification of one of the Colleges. But certainly in the more senior ranks of the hospital world that is very unlikely.

5037. What about anaesthetists, for instance?—They must be qualified either through one of the Colleges or through the Universities or the Association of Anaesthetists. If they are not admitted through one of the Colleges mentioned, they then have an adequate representation through the last one mentioned.

5038. That was why I was trying to differentiate between the two. Does the last body mentioned, that is the Central Consultants and Specialists Committee of the B.M.A. specifically break down, as it were, to represent any of the consultants who would not be covered by the first six?—It represents the whole of the staffing structure. It is democratically elected from doctors in Group Committees, Management Committees and the Regional Committees, then condensed into a Central Committee; from that Committee the six representatives on the Joint Committee are appointed.

5039. I have just one further question to get this clear in my mind. Psychiatrists, for instance, would normally be members of which of these various colleges?—They automatically can be members of, or are represented in the College of Physicians and a very high proportion of them, of course, would be Members or Fellows or Licentiates of one of the Colleges of Medicine. It is possible that they may only have a University degree, but that is not the usual pattern.

5040. *Sir David Hughes Parry*: I want to take you to the next section, the young doctor and his choice of career. You made your recommendation about him on the footing that he will be about 27 years of age before he can take any decisive step in relation to his professional career. National Service will soon be disappearing and then we really ought to be planning on the footing of 25 years of age?—Yes. I think that is about correct. It would appear though that that will be later than 25; it may be nearer 26 without National Service.

5041. Then in paragraph 20 you say: "Every consultant should be encouraged to take some part in the meetings of his specialist body, and it is a justified grievance of whole-time consultants that they are refused income-tax relief for subscriptions to these organisations and to the scientific publications." Part of that has now gone under the recent Act?—I do not know whether the Act has been implemented, but we gather that part of it will go, though not all of it by any means.

5042. I quite agree. In paragraph 21 there is a matter on which I am not

clear: "At present the grants made to Hospital Management Committees"—for the purpose of buying books and so on—"are inadequate and the libraries of few hospitals are satisfactory. The majority of medical periodicals and books essential for the maintenance of professional standards have to be purchased by the individual". Whom have you in mind in particular there?—I think that applies particularly to the whole-time person and the young man working whole-time in the hospital where his income is not sufficiently large to let him subscribe to a number of journals which may be important to him. We feel very strongly that it is there that the hospital should provide at any rate the main structure of literature, because as you are aware, medical literature at present is voluminous in the extreme.

5043. We have appreciated that a little, I think! I am now moving on to the next section. Is there any matter in any of these sections that you would like to add to what you have already submitted here? If so, will you take the opportunity when we are dealing with the section?—Thank you very much.

5044. "Difficulties encountered by Members of the Registrar Grades". I am in some little difficulty here, because you advocate in paragraph 27 an increase in the salaries of these two grades as urgently needed. Then on the very next line, in paragraph 28, you say: "Attention needs to be given also to the career prospects in these grades. Senior registrars are too numerous, in relation to the number of consultants" and so on. Now, if you make the salaries of the senior registrar and the registrar more attractive they would become even more numerous, would they not?—As you know, at the present time the competition for a senior registrar post is extremely severe. The number of applicants for any senior registrar post in general medicine and general surgery may be anything up to 15 or 20, all people who at that time might be considered very suitable for such a post. There is always that barrier at the senior registrar level and we think there will always be considerable competition for those posts. The other factor is those posts are governed by the establishment, an establishment that is agreed

between ourselves and the Ministry from time to time. The point, I think, that is rather made out in the slightly contradictory phrase is it does not apply only to senior registrars; it is the registrar below the level of the senior who also is in difficulties as regards his future prospects.

5045. *Chairman*: When you say that the competition for a senior registrar's post is extremely severe, is that because people want to be senior registrars or because they want to pass through that grade to become consultants?—If anyone is applying for a senior registrar post it almost implies that he has decided on taking up that speciality or a branch of that speciality as his permanent career. He may not achieve it but the vast majority of those senior registrars who have served a first or second year successfully will probably become the consultants of the future.

5046. He is applying for that job as a training post for a consultant?—As a training post for a consultant. That is really the main entry point into the consultant field.

5047. *Sir David Hughes Parry*: You would agree, would you not, that it is difficult to get into general practice once you are a registrar?—Yes.

5048. If you attract more to it than you can absorb, then you are creating a problem again. But there is an establishment and therefore you cannot take more but you can attract a better class; is that right?—Yes, that is it.

5049. *Chairman*: There is a very sharp distinction, is there not, between a registrar and a senior registrar?—Yes, very sharp.

5050. *Sir David Hughes Parry*: I have nothing on "Emigration" to raise unless you have anything to add. "The relative advantages and disadvantages of different forms of service" begins at paragraph 35. We want to compare the advantages and disadvantages of part-time and full-time service; we regard that as a very important matter. I have looked through the different documents we have received and I have here listed a number of the advantages and disadvantages of the two, full-time and part-time consultants. I would like you to help us to see whether we have got

the right answers. The advantages of the part-time service seem to me of two general kinds: there are the advantages by reason of the conditions of service, and there are advantages derived from a better position as regards assessment by the Inland Revenue. You also in several instances have emphasised that the part-time person has an advantage in independence of outlook, and you also emphasise his freedom to practise privately. Those are the four main classes of advantages which the part-timer may have; is that right?—I agree.

5051. I am not going to deal with the matter of independence or his freedom to practise privately, because they are not in the National Health Service, if I may put it that way. They are not strictly relevant on this particular point. I want to compare the part-time and the full-time. We will take the items, I think, mentioned in this document. Would it be right that the part-timer is better off as regards travelling time?—Yes, that is certainly so.

5052. Then secondly the sessions are calculated by assessing the hours required to perform a given job, and then those hours are divided into sessions?—I would like to comment on that. When we agreed with the Ministry officials on the estimation of sessions we kept them very rigidly to half days. The question of hours came into it in order to give guidance to the Ministry, but that was never intended to be an exact computation of the number of hours done in any hospital. As you know, we would be extremely resistant to any idea that we should be clocked in or clocked out in any form in the profession. We felt that perhaps the calculation of time and the importance given to it by various Boards has been quite out of the spirit of the original agreement. Every man may work at a different speed, but essentially what a man gives in half a day was to be the unit by which the part-time work would be assessed, without ever having to go down to details of hours and fractions of hours.

5053. In general, the hours are rounded up into sessions; is that right?—They are rounded up. I do not think that that is what we refer to as being exactly the spirit of the thing. The original contract of the part-timer was made with the Board of Governors or with his Regional

Board on an assessment of the work he would be doing, roughly split into half days, not into the number of hours he spent at one hospital and then the other. It is impossible to compute the amount of work any one man does in a unit of time. Some may work faster, some may work slower, and we have always held this half-day basis as being the only really fair assessment.

5054. *Chairman*: I suppose it is also true that from one time of the year to another the load on any consultant can vary very considerably?—It may do in some branches of the profession but I do not think it would apply in the general streams of medicine and surgery. I think the load is fairly steady; not even August and September seem to bring much relaxation.—*Dr. Stevenson*: I am not quite sure why Sir David thinks this particular point is one of the advantages of part-time service.

5055. *Sir David Hughes Parry*: One fact is that the hours are always rounded up.—Well, if that is to be the interpretation, there was always a certain amount to be allowed for emergencies and extra visits, visits that anyone pays to a hospital, shall we say, on his own just to see how this and that patient is getting on, which was not part of the original form of contract.

5056. He could choose the time?—In that sense he could choose the time, whereas on the actual sessions he is on a fixed time schedule.

5057. *Chairman*: Is it correct that in the actual Terms and Conditions of Service the number of hours per week for which a part-time specialist should be paid is determined by a prescribed method which does involve a rounding-up?—Yes, it does.

5058. I think that is a fact?—But I think it does say that this is only a general guide.

5059. Yes?—I have not the exact words before me, but I think you will find the timing method was only given as a rough guide to help people assess the original contract session.

5060. Is it not so in most parts of the country, that what you suggest has really happened, that it has been used as a rough guide, and that an assessment has been made as to whether a job is a five or six or eight or nine session job

and advertised accordingly?—Yes, that is it.

5061. So on the whole that works not too badly?—No, not too badly.—*Dr. Rowland Hill*: We ought to emphasise that it works both ways. It has been a characteristic of the Service since 1948 that of the man working, say, six sessions, in practice 99 men out of 100 have never hesitated to work ten or eleven if their patients require it. We have always agreed that it would be inappropriate for us to put down our masks and our stethoscopes when our hour had expired.

Chairman: I think that is appreciated.

5062. *Sir Hugh Watson*: You do not work to rule.—We do not want to be forced to.—*Dr. Cameron*: There is the point that we discussed at our last meeting, of the continuing responsibility of a part-timer. While he is assessed on a notional half-day, the remainder of the day he will still have responsibility for his hospital service.

5063. *Sir David Hughes Parry*: I put to you the question whether the full-timer also had the same responsibility, and I thought we had agreed that the one cancelled out the other on that.—

Mr. Holmes Sellers: I would not like the impression to arise that the part-timer had finished with his responsibility when it was not session time, apart from the obvious things like emergencies.

5064. *Chairman*: Equally, the full-timer also has a continuing responsibility throughout?—Yes.

5065. *Sir David Hughes Parry*: Now let me come to the weighting. You would agree that the weighting favours the part-timer?—It did before the last award in the Hospital Service.

5066. But it still does, to some extent?—It does slightly; but it is nothing like the original. That weighting of course does include a number of imponderable things that we, rather vaguely, have been trying to put before you.

5067. The next matter is the expenses of travelling to work; the expenses, not the time. The expenses for travelling to work are covered for the part-timer in the same way as the full-timer?—We have always felt that the whole-timer ought to have that concession, instead of it being inferred that with his limitation on car expenses he might even have to travel by public transport; it is quite

difficult for a busy person who has to be called out on emergencies.

5068. That might also be said of other professional men.—*Dr. Rowland Hill*: I was hoping that Sir David would look at this from a slightly different point of view, namely, the way in which the whole-timer is worse off, and not the way in which a part-timer is better off.

5069. I am dealing now with the advantages; afterwards I am going to ask for the disadvantages. Domiciliary visits; there is an advantage there?—*Mr. Holmes Sellers*: A very slight one. It is not as big as it appears on paper, taken over the whole profession.

5070. Will you tell me what the disadvantages of the part-timer are, because unfortunately you have not set these out as clearly in the memorandum as I should have liked. I have some difficulty in getting at the disadvantages of a part-timer.—Well, I do not know that one could really suggest there are very many. After all, the man has chosen his independence of action or has been allowed to take that independent course to give him that extra freedom from work under the Health Service. It does allow him the freedom to engage in private practice as you have said. Of course, the major distinction between these two branches is the attitude of the individual. Some people are quite convinced that they will work better on a part-time basis with a little outside interest or outside competitive thought; others feel that they do their best work if they are working whole-time in the Health Service.

5071. *Chairman*: Are there some part-timers who would like to be whole-time and cannot get an offer of such a job or who would at least like more sessions than they are able to obtain?—There will be a number of part-timers who will certainly want to take more sessions if they have only got a very few, for purely economic reasons. That applies particularly to the young consultants who are appointed to three or four sessions and have no other means of support. One can envisage that if the choice was available of becoming a maximum part-timer or a whole-timer instead of just having four or five sessions he would willingly take the greater number on economic reasons.

5072. I was trying to suggest perhaps some disadvantages of part-time. I

wondered whether that was one?—Yes, it is.

5073. *Sir David Hughes Parry*: To put it a different way, the full-timer has more security than the part-timer?—*Dr. Rowland Hill*: That is quite true. I believe it is the case that he has a slightly stronger legal security of tenure than the part-timer.

5074. I have given you the opportunity to bring out the disadvantages of the part-time service.—There is one I have just mentioned, a certain insecurity of tenure. Another one is unquestionably, in the case of a part-time consultant doing a good many hospital sessions, the stress and strain of that life where the demand on his private practice as well can be very great. Putting it another way round, in a phrase that was often used by Lord Moran, many men have chosen to be whole-time for the more undisturbed nature of their professional life, particularly if they were interested in some form of research or study. Every part-time consultant could tell of the stress and strain of that life. At the same time, most of them would not give it up for anything. But it is a disadvantage from that point of view. Then, another disadvantage is that already mentioned of the young consultant—and we can give many examples—who begins with perhaps two sessions in consultant practice and has no private practice. He has to apply in competition for more consultant sessions and hopes gradually to get up to a living income. That must be an anxious period for many young consultants today. A third disadvantage in practice is that the part-time consultant sessions are often spread over quite a number of hospitals involving him in a lot of travelling. We quite agree with the Ministry of Health that in future planning the more that can be cut out the better. But it still remains today as a disadvantage in the life of many part-timers, whereas most whole-timers will be found to be concentrated upon one hospital or one hospital group.

5075. Not all?—Not all, but the great majority.

5076. *Professor Jewkes*: Is it not a fact that the part-timers with less than the full number of sessions have a superannuation scheme which on the whole is not quite so attractive as that of the whole-timers? Is this not another disadvantage?—I would not really like

to give a definite answer to that question. We are not sufficiently expert on that. Perhaps Mr. Holmes Sellors has a more definite view.—*Mr. Holmes Sellors*: I think you are right.

5077. The point you make in your own document is that the part-timer not on the full number of sessions is in fact in an ordinary insurance scheme, whereas the whole-timer has his pension based on his earnings in the last three years of his professional life which gives him an automatic safeguard against inflation, something which is not to be sneezed at in these days.—There is a point there. The nine session man, in other words the maximum part-timer, is allowed the choice of the two, but below that not.—*Dr. Stevenson*: There are, I think, two other disadvantages, if I may put it that way. Firstly, there is the part-time consultant who may be maximum part-time but who will in fact through the exigencies of the service be doing far more than the maximum number of sessions, for which he is not paid. Secondly, a possible disadvantage is that if a hospital has to be re-organised through changes in medicine or a change in use, it may always be possible that a consultant will have the number of sessions reduced.

5078. *Chairman*: On balance, would it be fair to judge the relative advantages and disadvantages under any system by whether there is much of a trend in the one direction or the other in those specialties where it is very easy to make a change? We know there are some specialties where it is difficult to change.—*Mr. Holmes Sellors*: I think the Regional Boards have given consultants the chance of choosing between whole-time and part-time in some cases and there has been a steady drift towards part-time. A number of people who were whole-timers have certainly become part-timers since the Act and even in quite recent years. I think that this is, if anything, the pattern, though there are inevitably a number of people who would choose whole-time as a personal choice.

5079. There are some specialties where it is almost essential to be?—It is almost implicit in the terms of service.

5080. *Sir David Hughes Parry*: Private practice is with a doctor as with the lawyer, a matter of great risk.—

It is a matter of great risk at the present time.

5081. That would mean a substantial number of sessions would mean all the greater security from the State?—The man who is approaching the maximum is more secure, in one sense.

5082. You mentioned that the young man at the early stage with only two or three sessions was pretty insecure. I want to put it to you that the man who has seven or eight sessions and a private practice has the security of the State behind him; that is the other side to it.—The young man, of course, is not likely to have any appreciable private practice. That comes more in middle age.

5083. But it is a great security for a man getting on in years that he has the State behind him as well. We are trying to get at their relative position because we think it is very important.—Yes.

Chairman: You were kind enough to give a good deal of evidence on this point in December last, and Dr. Hill gave us his personal position in some detail, so we do not want to go into this in very much more detail.

5084. *Professor Jewkes:* There was what I thought was one new idea that was put to us in your Supplementary Memorandum that bears directly on this subject. It is on page 1134. You are talking about whole-time and part-time consultants there and you mentioned that when a whole-time consultant transfers to maximum part-time, he "almost invariably gives his employing authority an undertaking to continue to fulfil all the duties of his appointment as hitherto". That is a quotation from your document. That would be a case where the part-timer would be under a serious disadvantage because he would be taking a smaller salary for the same work.—*Dr. Rowland Hill:* It really depends upon what you mean by a disadvantage. It is a worth-while disadvantage. It is a slight liberation; it is just that little bit of extra freedom. Although it brings in an element of insecurity, most men hope to make that up, at any rate by a modicum of private practice. For example, in one of my hospitals at the present time a whole-time radiologist and a whole-time pathologist have both applied to do maximum part-time for the very reasons that

I have mentioned—they want to get out of the whole-time atmosphere a little bit. That compensates for the loss of two sessions.

5085. *Chairman:* Can I follow Professor Jewkes' point a little further? Do you know of any cases in any hospital where somebody who has been whole-time, which is 11 sessions, has gone on to maximum part-time, which is 9 sessions, and another consultant, a young huddling one, for instance, has been appointed for the additional two sessions; or does that never happen?—I think in all my experience of a good many non-teaching hospitals I have never known it happen.—*Mr. Holmes Sellers:* The majority of the advertisements, as they appear, are for whole-time or maximum part-time. But I gather the appointing Committees allow the successful candidate to decide which course of action to take after being appointed.

5086. *Mr. Benham-Carter:* In fact the same amount of work would be done?—The same amount of work would be done. A number of those on maximum part-time, of course, actually undertake more sessions than the nine. I believe my number, at a rough estimate, is to the neighbourhood of twelve or fourteen.

5087. *Sir David Hughes Parry:* Do you think we have now got the advantages and disadvantages of part-time and full-time, apart from income tax?—I think so, Sir. I would just like to emphasise again, as Dr. Rowland Hill has said, the rather spiritual side of the independence that a great many of us attach so much importance to.

5088. Let me go just one step further on that. In paragraph 38 you make a lot of that: you say that the whole-time consultant lacks the sense of professional independence. I am not concerned with his work with his private patients, but does that affect his work in any way within the National Health Service?—No, it would not affect that at all. The whole-timer and the part-timer are the two people who are giving exactly the same type of service professionally. The difference is in their own mental outlook to it; that is the easiest way one can explain it.

5089. Is that reflected in the National Health Service?—It is not reflected in the National Health Service itself.

5090. I think we are agreed on the income tax advantages of the part-time person?—Yes.

5091. The question of the car seems to be quite an important item?—Yes.

5092. The question of the telephone?—Yes.

5093. The question of the instruments?—Yes.

5094. And books and journals?—Yes.

5095. And attendance at conferences?—Yes.

5096. Our difficulty is that we cannot alter the law; we have got to take the law as it stands. You are not claiming better terms for members of the National Health Service than for members of other professions, are you?—If it was included in the terms of a man's engagement that he should have certain things available for the correct performance of his work, that would overcome that.

5097. But that would give him a great advantage over other people earning fees?—Well, I wonder if the medical profession is not in a rather individual position. The telephone may be a universal object but it is an absolute necessity to any medical man.

5098. The advantages of the part-time person are quite substantial, we would agree with you.—*Dr. Rowland Hill*: They are the disadvantages of the whole-time person. They are like galley slaves.

5099. That leads me on to my next question: that probably suggests that there might be a little more weighting for the full-timer as we cannot affect the income tax position in his favour. *Dr. Stevenson*: May I just add this? We never expected anything except to operate within the scope of the existing income tax law. But I might, with respect, draw your attention to paragraph 53 which, of course, is the alternative way of dealing with the problem. We think that the whole-timers have never had the intentions of the Spens Report properly implemented on these particular expense items.

5100. The difficulty would be that it would put your profession in a different position from others.—*Mr. Holmes Sellers*: I do not think so. The Spens Committee did make certain recommendations which we consider have not been fulfilled in connection with these ex-

penses.—*Dr. Stevenson*: I will give a simple example. A whole-timer is required, for obvious reasons, to be in possession of a telephone. The Board will pay him for outgoing calls but unless his income is below a certain level, which is a low one, he is entitled to no reimbursement for telephone-rental. That is only an example, but it shows one way in which his position could be improved.

5101. *Mr. Gunlake*: Could we go back to the tax angle? I thought I understood *Mr. Holmes Sellers* to say that if a consultant's employing organisation were to make it a condition of his contract that he should have a car and so on, the tax relief would be allowed. Did I understand that correctly?—*Mr. Holmes Sellers*: I am not sufficiently well versed in income tax law. He ought to be able to recover the expenses from his employing authority; that would be a more accurate way of expressing it—just as we mentioned in the case of the telephone.

5102. The expense, not the tax?—I do not know that he could.

5103. *Sir David Hughes Parry*: He would have to pay tax on any relief that he might obtain in that way.—*Dr. Rowland Hill*: I believe this is where Health authorities could operate within the law if they were a little more generous. A phrase in regard to a whole-time officer's salary is that the income tax authority will allow him relief on expenses which are necessarily incurred in the course of his employment. Time and again we have asked the Ministry of Health and that still more static body, the Management Side of the Whitley Council, to instruct the hospital authority to embody that clause in the whole-timer's contract. But they have never consented to do so. The result is that no whole-time consultant, although a car is absolutely necessary to him, has ever had it put into his contract that the possession of a car is necessary to his post.

5104. *Mr. Gunlake*: That is the point I was trying to pursue. Why have they refused?—Perhaps in public I ought not to express my views as to why. It seems to be a lack of wisdom and a lack of a general breadth of mind and a general Northcote Parkinson outlook.

Sir Hugh Watson: It is quite possible, coming back to *Mr. Holmes Sellers*'s

point, that the Spens Committee should not have said what they did about presuming what the income tax authorities would do. I do not think, with great respect, that Sir Will Spens had any right to say that, because, as you appreciate, this affects many other professions besides yours. I do not think we should blame the Inland Revenue authorities for that.

5105. *Chairman*: You know, Mr. Holmes Sellors, that the figures about consultants' earnings in response to our questionnaire will be coming in quite soon; in fact, some are in already. As I understand it, we shall get a pretty clear idea of the spread between the different numbers of sessions, whether it is one, eight, nine or whole-time. We will find a particular relationship, no doubt, between the part-time and the whole-time. But that will not by itself take any account of the difference in tax treatment on the point of the expenses. That might be something that, since we are not concerned with the income tax law, we might require to take into account. Is that also your point of view?—*Mr. Holmes Sellors*: That would be perfect. We know quite well we cannot touch anything to do with the income tax through this or any other body.

5106. *Professor Jewkes*: Leaving income tax on one side, could you give us some lead on this matter: which of these differences between whole-time and part-time consultants do you think is most important? Am I correct in assuming that it is domiciliary visit payment?—No, I do not think that is the important one; I think that is the least important of what has been mentioned. I think the question of car expenses and travelling time are more important. I think travelling expenses and for a medical man the presumption we must make is that that means a car, which at the moment, as you will appreciate, means expending a very large sum each year.

5107. *Chairman*: We have understood, particularly from Dr. Rowland Hill, that for the man to have his freedom is perhaps the most important of all things?—*Dr. Rowland Hill*: I think there is no question about that.

5108. That is what you said in December.—That is what compensates for all the disadvantages of being a part-timer. That is why, perhaps, I find the word "disadvantage" a little difficult to

follow. There are acceptable disadvantages.

5109. You are, I think, saying, Dr. Hill, that it is worth having a little bit less remuneration in order to have your freedom. Your total earnings might be a little less, but in order to justify the freedom you are prepared to accept that?—I emphasise that with great force, yes.

5110. You would not think that the earnings of the part-timers, the people of about comparable ability, ought in fact to be higher than the earnings of the whole-timer?—*Mr. Holmes Sellors*: I think that is entirely dependent on facilities outside, in other words, private practice. That will be their other definite source of income which doubtless will be included in the figures you will receive.

5111. I am just trying to get at what Dr. Hill, I thought, was saying, which was that on the whole the whole-timer should not earn less because he has the additional disadvantage of being a galley slave?—*Dr. Rowland Hill*: Yes. We do not want any section of consultant to be treated inequally. But there is no doubt that if no such thing as private practice existed and if there were no differences in income tax law, it would still be the case that the great majority of consultants would wish to be part-time because the great majority of men—I cannot speak for some future generation, but the great majority of the present generation of consultants—do not wish to be whole-time salaried officers of a public body.

5112. *Sir David Hughes Parry*: I am very interested that the movement is in favour of maximum part-time. That means maximum security as well as independence?—*Mr. Holmes Sellors*: Not maximum security; it is only maximum part-time.

5113. It is maximum under the system as it is now.—*Dr. Stevenson*: Could I come back to something you said; I was not quite sure what the import of your question was. I think you said we would be in favour of there being a possibility of the part-timer getting less than a whole-timer. I think probably we would like to say, if that was the point of the question, the weighting, which no doubt you will be referring to later, was intended to compensate for some of these

disadvantages inherent in the part-timer's contract.

5114. *Chairman*: Yes, I appreciate that.—I think that is important.

5115. *Mr. Watson*: Dr. Hill did not put it that way. He placed a great deal of stress and weight on what he termed the spiritual release of a consultant. Would Dr. Hill accept it as a general principle, applied to the Health Service as a whole, that the persons employed full-time should have a higher form of remuneration than those who have got a spiritual release and who are part-time with a private practice?—*Dr. Rowland Hill*: I would not have said that, Mr. Chairman. I would accept that the pro rata remuneration for hospital work in the Health Service really ought to be the same.

5116. *Professor Jewkes*: By the same, you mean roughly what it is now?—Yes.

5117. *Mr. Bonham Carter*: May I clear up one point which bothers me about what has been discussed on income tax? It always surprises me that you have got a uniform treatment from Inspectors. One's experience of dealing with people all over the country is that one gets rather different treatment from different Inspectors. Is it your experience that you get exactly the same?—*Mr. Holmes Sellers*: I think what you say is perfectly true. I think the Inspectors interpret quite differently in different parts of the country. That has been one of the difficulties in another discussion we have been having before the Special Commissioners. It is not always the same; but by and large the principles that have been established are the main features and operate fairly generally over the country.

5118. *Sir Hugh Watson*: Could I clear up one point? We know that a maximum part-time consultant is responsible for his patients whole-time, and we know that you yourself have said you do twelve or fourteen sessions. There was a statement in paragraph 60 which puzzles me in that connection; "... few consultants can devote as much time as they would wish to seeing a new patient at hospital. Private practice makes it possible to see patients at greater leisure ...". What does that mean?—If you take a session of out-patients at which there are 15 or 20 new patients

to be seen in, say, three hours, it is quite clear that less time will be given to those patients than in seeing a private patient, when often a half hour or an hour is allotted to each patient.

5119. You have got to limit your sessions to three hours?—Not to limit, but there is a session basis and the appointments system gives new patients and old patients to an individual consultant, as many as they think he can deal with in that particular out-patient session.

5120. As many as he can manage?—If he had to deal with all the list that came to him, say, every afternoon he was doing out-patients, he might never finish until midnight or after.

5121. That is where your twelve or fourteen sessions might come in?—Well, there has to be some limitation unfortunately. I think if I may put it rather unofficially, the slight difference in the handling is that, to put it rather crudely, in an out-patients' session the patient listens to the doctor, whereas in a private practice the consultant listens to the patient.

5122. *Chairman*: That again will vary from specialty to specialty?—Yes. A surgical consultation is obviously a much shorter one than a lot of medical examinations.

5123. And it would not apply so much to a radiologist or an anaesthetist?—It would not apply so much.

5124. *Mrs. Baxter*: I am not clear why the category of whole-time consultant has to be continued at all. Is it merely a question that some specialties require full-time hospital appointments? Otherwise why does not the consultant obtain the spiritual release so strongly desired by working 9/11ths, and why cannot the whole category of whole-time consultants be abolished, thereby releasing everybody both from income tax problems and from the galley?—*Mr. Holmes Sellers*: Of course, there are a number of new circumstances in which a whole-time officer is essential. It is implicit in the terms of work, and speaking, many of us, as part-timers, we cannot dictate to the man who wishes to work as a whole-timer. There is a slightly different outlook on the work. Some people have found they do their best work in the whole-time atmosphere; others feel that nothing would induce

them to work in a whole-time atmosphere.

5125. *Sir Hugh Watson*: There are still some Britons who are prepared to be slaves!—You said that!—*Dr. Rowland Hill*: I would underline what has been said by quoting the agreement with the Ministry of Health. The Ministry agreed to instruct all hospital authorities that offered contracts to consultants, to the effect that if they wanted a consultant for a given post whole-time they were to give him after appointment the option of being part-time or whole-time, and there is a corollary to that. Any consultant taken over whole-time into the service in 1948, or even whole-time since, has the right to apply to go on part-time. There is one limiting clause to that. If a hospital authority feels that for medical reasons a given post should remain whole-time, they must say so and the onus is on the hospital authority to show that the requirements of the post are such that for medical reasons it must stay whole-time. With that exception, every consultant should be allowed if he wishes, to become maximum part-time. Of course, the service has inherited from before the service days quite a lot of consultants who had become attuned to a whole-time life, and they comprise to-day the great majority of whole-time consultants in the service.

5126. *Chairman*: I think you are referring to the agreed statement set out in full on page 25 of the factual memorandum,* which does contain the phrase "subject to the over-riding needs of the hospital service." That phrase might apply with special force in mental hospitals.—Possibly yes, and to people working in laboratories.

Chairman: I do not think there is any dispute about that. It is set out as an agreed statement.

5127. *Sir David Hughes Parry*: There is one question of fact on paragraphs 39 to 41 of your main memorandum. You say "This type of consultant is probably the most numerous within the Service." Then in paragraph 41 you are more specific. You mention this: "The advantages, both financial and non-financial, of the maximum part-time consultant are such that the great majority

of consultants—over 70 per cent—prefer this status."

5127A. *Chairman*: I think there was a slight mistake, Mr. Holmes Sellors, in your earlier evidence. You referred to 70 per cent of the part-time people and here you refer to 70 per cent of the whole lot.—*Mr. Holmes Sellors*: I am afraid that is a round figure, and our source of information was in the discussion with the Ministry. They gave us the figures.

Chairman: There is a discrepancy between what you say on the two occasions.

5128. *Sir Hugh Watson*: On paragraph 34, which is a quite separate point—emigration—you say that many members of the profession are driven to emigrate and that this reflects dissatisfaction with the present conditions of medical practice. Are you referring to financial conditions, or other things?—I suppose finance is a very large one, but the other is the very fact of working in what people feel is a State monopoly, and that the prospects of promotion for a large number of young men are very small in this country compared with the conditions they can see overseas. The United States of America will take any number of our well trained young men. Whether they keep them is up to the individual.

5129. *Chairman*: In general, the rate of emigration is no higher than in the population generally?—That I am not prepared to say, but we have lost a great many consultants and senior registrars to the North Americas and other countries, and they have not come back.

5130. *Mr. Watson*: Could anything be done by retiring consultants and doctors earlier? Do you think any useful purpose could be served by considering an earlier retirement of consultants and doctors so that the line of promotion could be easier for the younger man?—No, I do not think so. I think there is a fairly marked resentment on the part of people who are approaching the age of 65 that their services should be considered to be no longer useful to the State.

5131. So the question of emigration has nothing to do with the Health

*Royal Commission on Doctors' and Dentists' Remuneration. Written Evidence Vol. I.

Service? That is, as such?—There are some people who feel most strongly that they would not work under anything which resembles a State service or is being controlled by any bureaucratic organisation.

5132. *Chairman*: I wonder if Mr. Cocker has anything to say on this?

—*Mr. Cocker*: We find we do get some of our young men emigrating and our position is, I think, considerably worse than that of medicine. We have a number of young trained registrars who have not the remotest prospect of getting a consultant's post because there are not the consultant posts for them. In medicine, taking it over a period of time, there is an increase of about 30 per cent in consultant establishment and for dentists it has only been 7 per cent. Taking a limited period, in the year ended June 30th, 1957, there were seven fourth-year senior registrars. The only appointments advertised for them in 1957 were one of two sessions and one of three sessions. Men are not going to give up seven years of training when, after qualifying, they know there is no, or very little, prospect of getting a decent job and when they have the prospect of going into private practice and at any rate making a reasonable living.

5133. *Professor Jewkes*: I wonder if Mr. Holmes Sellors thinks there is any advantage in raising the retiring age. Have there been any discussions on that?—*Mr. Holmes Sellors*: There have been a number of discussions but if you raise that it upsets the prospects of the younger men considerably.

5134. *Chairman*: Do those who are doing a considerable amount of private practice normally stop doing that and retire from it at the same age?—No, they usually continue in private practice, but it is well known from past years that a man who severs his connection from routine hospital work finds that his practice tends to run down, and as a pure guess I should say they have at least three years' private practice before the run down.

5135. Surgery is something in which the powers decline?—It is an individual matter. It is the old battle, that experience only come with time as does the loss or limitation of faculties which affects each doctor.

5136. But I thought, perhaps, that in surgery the decline in faculties became more important than in medicine.—Yes, but I do not think surgical faculties are dimmed any more than any other part of the profession.

5137. *Mr. Gunlake*: It has been put to me that it is difficult for a man to carry on after retiring from the Health Service. You reassured me on that, but does the same difficulty exist in some degree in some specialties? Are there some specialties where it is impossible for a man to carry on private practice?—There is, theoretically, access to beds in private hospitals.

5138. Which are expensive.—But it does not stop his ordinary practice. It certainly does run down, but I should say three years was the average time for a person doing a considerable proportion of private practice.

5139. I think the retiring age is normally 65 but a man can be kept on up to 70. Have you any information as to the extent to which that has happened?—I should have thought it is not done extensively.

5140. Most people go at 65?—Yes, because so many doctors are aware of the pressure from below. They feel that in fairness they should not continue with their work. Indeed, according to the regulations, they should not.

5141. *Chairman*: You have not got any statistics on that?—No. I should have thought the Regional Boards would have that. But if a man is employed beyond the normal retiring age it is usually in a different capacity.

5142. *Mr. Gunlake*: What is the position of people who have retired since the Health Service started, or who are going to retire in the near future? I do not mean those who will retire 30 to 40 years hence but the people who are now retiring and getting a very small pension only under the scheme which applies to them. Their goodwill has no saleable value and never had. What will be the effect on those men? Will there be hardship?—I think a number of them will suffer considerable hardship. A number of them who took out endowment policies are better situated, but those policies may not be worth what they are thought to be. The man only just qualifying for a pension certainly has a very poor income to live on after

his retirement from the service. I think that has been one of the very real hardships we have seen. The war years have, of course, upset the economic prospects.

5143. *Sir David Hughes Parry:* We have taken the point in your memorandum about the consultant's liability for committee work. There is nothing I want to raise on it, and we have dealt with quite a few points on superannuation. There is only one other matter, on paragraphs 93 to 96, dealing with negotiating machinery. We are leaving a good deal of that for private discussion with you later, but there is a very important matter which we think ought to be raised in public. The last sentence of paragraph 93 reads: "There are, however, strong arguments in support of direct negotiation when major matters of finance or other questions of national importance are involved." Before you reply to that may I explain that we have had a number of proposals on negotiating machinery and we are going into each one as deeply as we can to see how they differ. We want them to be as specific as possible. This is rather general. I do not know if you can assist us by saying what is intended by "other questions of national importance."—I think that would imply the major political issues that we deal with to some extent in direct consultation with the Ministry officials but which, because they may imply certain alterations to the conditions of terms of service have to be referred to Whitley. We are using a double method of negotiation. One is Whitley and the other is one in which we discuss directly with the Ministry officials any questions of alterations in the service not connected with the "Terms and Conditions."

5144. Whatever now is a matter of direct negotiation between the profession and the Ministry and not included in the Whitley machinery, you would wish to be henceforth a matter for this body. Is that what you are asking?—No. Possibly we may be getting at cross purposes or perhaps I have not put it clearly. I do not think we have any wish to alter the mechanism by which we have direct consultations with the Ministry and the Ministry officials or even the Minister himself to deal with questions of policy. When, however, any matter that is covered by the Whitley

agreement comes in, it cannot be discussed. It has to go into the Whitley machine. You have heard that we are not entirely satisfied with the Whitley machinery as it works at present.

5145. In paragraph 95 you say: "In addition, the Committee recommends that there should be set up a small advisory committee . . ." Advisory to whom?—Advisory to the Government.

5146. The Government as such? It must be to the Treasury, or to the Prime Minister?—To the Prime Minister.

5147. To the Prime Minister?—Yes. If I may come back, as you probably know we are entirely dissatisfied after 10 years' experience, with the Whitley machinery for dealing with any major matters of finance. We agree that it may be made to work in the smaller, day to day, bread and butter matters, but there has been very much a sort of inverted Micawberism of the management side of Whitley. They are always waiting of something to turn down rather than to turn up, so that we are not prepared to consider dealing with any major finance matters in Whitley if we can help it. In fact, any major alterations have not really been through the Whitley machine. Our original claims were rejected by the Whitley machine.

5148. Other questions of national importance have been dealt with by the Minister of Health?—*Dr. Stevenson:* Nearly everything which a consultant does in the National Health Service is covered by a document which is his Terms of Service. Under the present set-up no amendments to those Terms of Service can be made without the ratification of the appropriate Committee of the Whitley Council. As Mr. Holmes Sellers said, many of the items in the Terms of Service may be of supreme financial or national importance. I should like to give you two examples. The present claim is one of supreme financial importance which is unsuitable for Whitley. It may be that we shall object to the cost of private beds. That has nothing to do with the Terms of Service, and is quite unsuitable for discussion with the Whitley Council. In our opinion it is a body which is quite unsuitable to discuss matters of national and financial importance.

5149. You are proposing that lay persons should be appointed and they will deal with medical remuneration, directly advising the Prime Minister, behind the back of the Minister of Health?—Possibly we were a little hasty on that. Obviously they would advise the Minister first.

5150. *Mr. S. Watson*: Is this advisory committee purely for the consultants?

—*Mr. Holmes Sellers*: No.

5151. It is for the whole of the medical service?—When we say national importance what we really infer by that is inflation.

5152. *Chairman*: Dr. Stevenson has just mentioned two particular examples. One was the present pay claim and the other was the price of pay beds. Is it your view that this body of eminent laymen should consider the price of pay beds?—*Dr. Stevenson*: No.

5153. Then who would do it? You cannot have two bodies, one Whitley, which you say should not deal with pay beds, and the other a body of eminent laymen. . . .—Direct negotiation.

5154. So you want three—Whitley, direct negotiation and a body of eminent laymen?—We are quite happy to continue with Whitley on the minor things and we want to continue to negotiate direct on other matters, but in order to stop wrangles on matters of national and financial importance we suggest this third solution.—*Mr. Holmes Sellers*: Ending with the Minister as to final appeal.

5155. *Mr. Watson*: Would it mean that this small advisory body, which, apparently according to this memorandum must be set up in consultation with the medical profession—would that mean that your Committee has in mind a small advisory body without any responsibility whatever being empowered to make decisions?—*Dr. Stevenson*: We have based this really on the Coleraime Committee which, I understand, is a body of lay people who advise the Government.

5156. There is a much different employer-employee relationship there. Does this memorandum mean that this advisory committee would be set up, (a) only in consultation with the medical profession and (b), without any responsibility whatever, will it have the right to bring forward recommendations? Why should they have no financial or

other responsibilities inside the Health Service?—*Dr. Rowland Hill*: We felt there were many difficulties about this matter and would like to put them frankly in front of you because we did not feel we could give an answer, but what did attract us was when we saw the Royal Commission on the Civil Service and the setting up of the Coleraime Committee. In their report they referred to the managerial class and above where compulsory arbitration is not suitable and we feel much the same about the consultant. We were attracted by the conception of a high-level body like the Coleraime Committee which would keep the general financial status under continuing review in the same way as is done in the senior grades in the administrative Civil Service, but we were well aware that there were many differences. Naturally we were troubled about it. We thought we should like to put those thoughts to you, some of the thoughts and doubts we had and whether we should be prejudicing our negotiating powers and potentialities if we said we would hand over the whole of our future financial destiny to the advice of this committee, which, in fact, the higher grades in the Civil Service have done. We felt you could think far better on that subject than we could ourselves, but we want to emphasise this idea of some continuing high-level review on doctors', and particularly consultants', remuneration being desirable rather than having these quinquennial wrangles that we have had, like the one in 1954 and the other one which preceded the setting up of yourselves. Obviously the Government felt the same or they would not have given you your third term of reference.

5157. *Chairman*: I should like to get that clear. We are not trying to argue the merits of what you may think here, but we should like it to be quite precise. I think we are clear—that you say this is primarily designed to deal with the higher ranks of the medical profession rather than the whole of the National Health Service.—*Mr. Holmes Sellers*: We would like all medical remuneration to be subject to this review, but we do not feel that such a committee should have a place in determining alterations in our structure. There are obvious difficulties in appointing an eminent body of laymen with rather limited terms of reference. That we appreciate, but

we are seeking to stop this interminable wrangling and definite ill-feeling that goes on between the profession and its employers.

Sir Hugh Watson: The difficulty is very real. It was put by Sir Thomas Padmore that on all these matters they were going to have the last word. Successive Governments have always taken up that position. We are looking for something to bridge that gap.

5158. *Chairman:* I think you make the point in paragraph 96. You do not, however, Mr. Holmes Sellors, simply say that it is to keep under continuous review the general level of remuneration of doctors engaged in the National Health Service. You give one particular qualification to it—"in order to maintain their proper economic and social status in the community".—Since this document was written we have been engaged in a number of discussions, trying to sort out this problem or to make some reasonable, concrete suggestions on it.

5159. *Professor Jewkes:* Might I ask Mr. Holmes Sellors this. This business of trying to draw a line round the reviewing body and deciding that these are the problems which it must deal with and those are the problems which the profession must deal with, is really vital. I can quite see that the kind of pay claim you have already made would come to any proposed reviewing body but you say, "We do not want that body to deal with questions of distribution". Supposing something had gone wrong with distribution inside the profession and substantial changes were wanted in the relative earnings of the different branches in the profession, would that come to the reviewing body?—I think we should prefer to work out any question of distribution more locally. I think we feel there would be too much danger of an eminent body deciding to change the structure by altering the salary scales, by altering them substantially. We feel that if we did not have some say in that we should be very unhappy.—*Dr. Stevenson:* I think we have said on another occasion that apart from the disputes to which Mr. Holmes Sellors has referred there have been few occasions on which we have not been able to reach agreement with the Ministry on these matters.

5160. *Chairman:* Can I go a bit further as between the first two of your methods? Have you got a fairly clear dividing line as to the difference between those things which should be dealt with by Whitley and those dealt with by direct negotiation with the Ministry?—*Mr. Holmes Sellors:* I would say I have a fair idea in my own mind, but whether I can make it clear to you is another point. In Whitley there are the bread and butter matters which affect the terms and conditions of service. On that we are satisfied. In the other field of direct negotiations with the Ministry officials again we are satisfied on matters of policy. Matters such as are likely to be pressing with us, the cost of pay beds and the like, we feel should be discussed directly with the Ministry officials. In Whitley we are discussing with an amorphous body. It is always the Paymaster element which comes into Whitley, and you feel that very strongly. Whereas in negotiation, where we are both trying to find a satisfactory solution we come very much to a reasoned agreement in our discussions across the table with Ministry officials or with the Minister himself. The agenda of our meetings are usually full of residual points which are important locally within the profession but are not concerned with any great alterations in remuneration.

5161. You add in your memorandum that the Whitley machinery requires to be drastically overhauled. Again I am not quite sure what kind of drastic overhauling you mean.—I think I have expressed the essential point. The whole point is that the staff side feel that there is Treasury control, that on any suggestion for any alteration of money the instruction is coming to the management side from the Paymaster.

5162. *Mr. Watson:* That is really inevitable.—We agree, but it does not make for easy discussion.

5163. Can you take it to the next stage? You suggest that the management side should be composed of Government officers with real authority to negotiate with the staff side. Those are the words you use. I take it you mean the Treasury should second responsibility to its officers to reach wage settlements with you?—*Dr. Stevenson:* That is what happens in other fields, the general practitioners' field.

5164. I am not saying it is not. But if that is so, what is the need for the advisory body? If you wish to have a Whitley Council on which the representatives of the Government, and the Treasury, go, with real authority to settle, why do you want any other authority?

—*Mr. Holmes Sellers*: Because ten years experience of bringing forward any major issue does not encourage us.

5165. It is your recommendation, not mine.—*Dr. Rowland Hill*: What we really felt was that when on any big major issues which we are responsible for, the Minister says "This is going to have some impact on national financial policy and will have to be considered at that level," that is where a high level committee might, we feel, be the best body to discuss it with. In 1954 when we made a claim on the full value of money, the Minister at that date interviewed us and explained the extreme difficulty of meeting the claim in the light of the national situation. It is a good many years ago now but I think he told us he was inclined not to permit any arbitration on that claim. It was only after prolonged negotiations that the 1954 agreement was reached. What we feel about Whitley is this. We feel that in smaller matters we never get to grips with the people who can say Yes or No. I believe that the Civil Service Whitley Council works rather well; I understand that the employing side is known as the official side, and the official side in that Whitley Council appear to have much more power of decision than has what we call the management side in our National Health Service Whitley Council. A large percentage of our management side is composed of members of Management Committees and Regional Hospital Boards who really have no power of decision, and that undoubtedly produces protracted misunderstandings and lengthy discussions. The misunderstandings spread and no decision is reached month after month.

5166. I wonder, Mr. Holmes Sellers, if we can continue on this. Quite frankly, some of us are very anxious to find a medium of negotiation. You say in this document that this body, the advisory committee, should be charged with the continuing duty of tendering advice to the Government on its own initiative. Has the Council really thought out the responsibilities of such a

committee and if it is going right down through the Health Service from A to Z, making all kinds of recommendations, such as, for instance, on the retiring age or a change in the per capita basis?—*Dr. Stevenson*: No.

5167. I am just asking if you have thought of all these possibilities. Is your purpose to limit this body only to one thing, the question of wages?—*Mr. Holmes Sellers*: That was our idea. The issues at the back of other people's minds as to whether the body should be a different one from what it is now, are not relevant.

5168. But you say "questions of national importance."—On that, which I think we have drafted badly, we did mean inflation or wars which are outside the course of economic and financial progress.

5169. *Professor Jewkes*: So you are suggesting for the reviewing body one task only, to give advice on the total sums which would be made available for payment of consultants and general practitioners in the National Health Service? There would be one figure?—*Yes*.

5170. *Chairman*: I think I am right in saying that the only drastic overhaul of the Whitley machinery which you are asking for is for Whitley to be composed of people who can give an answer then and there?—That is it.

5171. That is what you are asking for, or have I simplified it too much?—*No*, we have had ten years' experience of it.

5172. *Mr. Gunlake*: You would like to have people to come to the conference with open minds and not closed minds?—*Exactly*.

5173. You have the impression that at the moment they come with their line prepared?—*Dr. Stevenson*: They have met in the morning.

5174. *Chairman*: Is it also possible that you have made up your minds?—*We try to anticipate what the other people will say*.

5175. *Sir Hugh Watson*: But the occasions when that sort of thing happens, arise when there is a really major question of an increase of remuneration or something of that sort.—*Mr. Holmes Sellers*: They will do

it on almost any issue. Supposing we suggest a slight increase in the remuneration for giving lectures. That is the sort of negotiation that may take nine months, going backwards and forwards.

5176. You are in a different position from the general practitioners. Many of their discussions are concerned with re-distribution of the pool?—We chose to go to the Whitley Council and we have Committee B. Whether there might have been some other alternative I do not know.

5177. *Chairman*: I take it that when you go to Committee B you have done a certain amount of preparing with the other side. You are not putting quite suddenly, out of the blue, that you would like a change in the system?—There is a long exchange of documents.—*Dr. Stevenson*: We must be honest on this. I think you have put your finger on a real difficulty of Whitley, that the two sides do meet independently in the morning and consult in the afternoon, so that on many occasions it is not possible to get a decision immediately but in three months' time.

Sir Hugh Watson: You could not consult in the morning and meet in the afternoon, could you?

Chairman: I do not think there is much we wish to ask on your Supplementary Memorandum. It has a lot of very detailed information in it, in reply to questions which have been put, for which we are very grateful, and in fact some of this has been touched on in the earlier evidence this morning.

5178. *Professor Jewkes*: I have one point. In this memorandum you give evidence about the difficulty of getting registrars and senior registrars in a considerable number of hospitals in this country. The interesting statistics you give show the extraordinary dependence of a number of hospitals on foreigners. Does this mean that really the system is precarious in the sense that if these foreigners were withdrawn the hospital system would break down?—*Mr. Holmes Sellers*: In certain circumstances I think that is true. In one of my hospitals I am served by three people from India, there being no applicants from this country. In fact, we have not got a British born person on the hospital staff.

5179. *Chairman*: And this is more evident in the non-teaching hospitals?—Yes, the non-teaching and peripheral hospitals. The young man tends to like to be central.

5180. May I come back to the point we have left? If something prevented Pakistan, which happens to be a big contributor, from sending a lot of people over here and there was a considerable difficulty in filling some of these posts, which of the bodies you have mentioned do you think should take the necessary steps to ensure that there was a proper filling of the posts on the perimeter as well as in the centre?—That would come under direct negotiations with the Ministry, and in anticipation of a number of these problems the Minister has formed a Working Party of which there are several members before you now.

5181. If there is a shortage which suggested that steps should be taken to make certain types of post more attractive would you think that would go to Whitley?—I think that would be more a question of approach to the senior officials of the Ministry or to the Minister himself.

5182. So you put it in category two—direct negotiations?—The direct negotiation system works well and works relatively easily, because it is simply a question of finding suitable dates. That is very easy in present negotiations, I trust on their side as well as ours.

5183. *Sir David Hughes Parry*: How are those persons trained? Are the Indians and the Pakistanis trained in this country?—There is a mixture of both. Some have been through medical schools in this country; others have come over as post-graduates.

5184. That is an important part of their training?—Yes.

5185. But we should not be entirely dependent on them?—I think that is so, but I think we should fulfil our obligations of training post-graduates if they come to this country.

Chairman: What would seem to be desirable is that there should be a spreading of these people throughout the hospitals and not a concentration.

5186. *Sir David Hughes Parry*: And our own registrars want to be under the eye of the professor and those in the teaching hospitals and those associated

with them?—On the whole, yes. They do, of course, get the opportunity of greater freedom of action in the peripheral hospitals.

5187. They have one eye all the time on their own future?—Yes.

5188. *Professor Jewkes*: May I then draw the deduction that there is a shortage of British registrars?—In certain areas there is most undoubtedly in the number of applicants. I am not prepared to say whether it is due to any sense of insecurity that they are not continuing in the hospital service. We know the difficulty of getting the senior registrar posts filled.

5189. *Sir David Hughes Parry*: Might it not be that many of them go into the Forces at this time and do their National Service? When that ceases there may be better opportunities?—I should think that might be true. But National Service has worked in another way. The man who comes back from the Forces very likely feels he would like further hospital experience before he decides that he can go into private practice.

5190. *Chairman*: Is the registrar grade partly a training grade and partly a staffing grade?—It is the obvious course through which a man, in deciding on his future, will pass. It is a training grade.

5191. *Sir David Hughes Parry*: The extension and the increase in the number of registrars was a staffing problem?—Yes, and with the complexity and development of modern medicine a lot of people are needed in this way.

5192. *Sir Hugh Watson*: What happened before?—The team was a very different one. The team at a teaching hospital was a full surgeon and a junior surgeon, both having consultant rank, with one registrar who was the

equivalent of the senior registrar at present and one or two house surgeons. At the time when the Health Service started and the post-war people were coming back, there might be two consultants, from one to three senior registrars and two house officers. With some of the specialist teams we carried even as many as four or five.

5193. What happened in the non-teaching hospital?—In the non-teaching hospitals there were a number of medical officers under the administrative control of a superintendent or the senior man and then there were a number of house officers scattered about in accordance with the needs. There was no attempt to have a team.

5194. *Sir Hugh Watson*: But what I mean is this. The people from Sheffield paint a picture—and I know it is not confined to Sheffield—that the service would break down if we did not have these people from abroad. What happened before?—*Dr. Rowland Hill*: The effect of the Health Service in the teaching hospitals has been twofold. First, there was a great increase in the amount of work. For example, the effect of it on my own work was to double or treble the amount which came my way. Secondly, the immediate effect of the introduction of the National Health Service in 1948 was to upgrade the work of a lot of the hospitals which were, frankly, working before the war at quite a primitive level of medical work. As you know, the first attempt of the National Health Service was to spread the consultant standard of work evenly throughout the country and that at once meant an increased need for staff in all these hospitals.

Chairman: I think we will break off our public discussion at this point.

(*The proceedings were continued in camera.*)

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Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

22

Twenty-Second Day, Friday, 12th December, 1958

WITNESSES

Scottish Medical Practices Committee
Scottish Association of Executive
Councils

LONDON

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Questions 5299-5437

MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

TWENTY-SECOND DAY

Friday, 12th December, 1958

Present:

SIR HARRY PILKINGTON (*Chairman*)

MRS. K. M. C. BAXTER
MR. J. H. GUNLAKE, C.B.E.,
F.I.A., F.S.S.

MR. I. D. MCINTOSH, M.A.
SIR HUGH WATSON, D.K.S.

MR. W. A. FULLER, D.S.C. } *Joint Secretaries*
MR. J. B. HUME }

Observations by

SCOTTISH MEDICAL PRACTICES COMMITTEE ON

"Questions and Topics on which the Royal Commission would like to have the views of the Medical Practices Committees"

1. *A brief description of the Committee's own activities*

(Unless otherwise stated, the functions listed below are, so far as the Committee are aware, also discharged by the English Medical Practices Committee.)

The Scottish Medical Practices Committee was constituted in 1948 by the Secretary of State for Scotland under the National Health Service (Scotland) Act, 1947. Under that Act, the Amendment Act of 1949, and regulations made thereunder, the Committee are now empowered to discharge the following duties:—

S. 35 of the
N.H.S. (Scot.)
Act, 1947.

- (a) To consider and determine applications from doctors wishing their names to be included in Executive Council medical lists for the purpose of providing general medical services. The Committee may refuse an application, or may grant it subject to a limitation of practice area, only on the ground that the area or part of the area concerned is already adequately served by doctors. An applicant dissatisfied with the Committee's decision may appeal to the Secretary of State. The number of applications granted and refused by the Committee during the five years to 30th June, 1958 is given in Appendix I.
- (b) To consider applications from doctors for a certificate that a proposed transaction does not involve the sale of the goodwill of a medical practice which the Act made it unlawful to sell. The possession of the Committee's certificate is a defence in Court to any charge that an offence under the Act had been committed in respect of the transaction concerned. Most of the transactions in respect of which certificates are sought take the form of partnership agreements. The Committee have prepared a memorandum on the subject for the guidance of doctors or their agents; a copy of this is reproduced at Appendix II. (See also 7.)

S. 36 (9) of the
N.H.S. (Scot.)
Act, 1947.

Reg. 7*.

(c) To consider reports made by Executive Councils at least once every year, for the purpose of enabling the Committee to judge the needs of the different parts of the country for doctors. The reports are now normally called for at 1st April of each year.

Para. 2 (c) of
Part II of
First Schedule
to Regs.

(d) To consider applications, referred to them by the Secretary of State, from doctors for inducement payments and to make recommendations. These payments are intended to assist doctors practising in sparsely populated districts, or in districts which for any other reasons are unattractive to medical practitioners. There are at present in Scotland 47 practices which carry an inducement payment.

Para. 2 (a) of
Part II of
First Schedule
to Regs.

(e) To determine whether an initial practice allowance should be made available in a particular area on the ground that a practice is necessary therein for an efficient service. The allowance may be paid (i) to a doctor setting up a new and independent practice, or (ii) to a doctor succeeding to a small vacant practice. The considerations taken into account by the Committee in determining whether or not a particular district should attract an allowance are set out in Appendix III. (The Committee understand that the position in England is somewhat different.)

Reg. 8 (1).

(f) To consider the arrangements proposed by an Executive Council for dealing with a vacancy created by the death or resignation of a doctor, and, if they think it desirable, to require the vacancy to be advertised. The manner in which the vacancies arising in the five years to June, 1958, were dealt with are shown in Appendix IV.

Reg. 8 (3).

(g) To consider and determine appeals from doctors whose applications to Executive Councils for succession to vacant practices have been unsuccessful. Appendix V shows how appeals made in the five years to June, 1958, have been dealt with.

(NOTE—(f) and (g) represent the most important difference between the arrangements in operation in England and Scotland respectively. Whereas in England the filling of vacancies occurring in medical practices is entrusted to the Medical Practices Committee, appeals being to the Minister of Health, in Scotland the selection of doctors to fill such vacancies is a function of the local Executive Councils. The Scottish Medical Practices Committee are only the appellate body, and they have thus no say in the filling of vacancies save in the comparatively few cases where an unsuccessful applicant appeals against the choice made by the Executive Council.)

Para. 8 (3) (a)
of Part I of
First Schedule
to Regs.

(h) To consider and determine appeals from doctors against decisions of Executive Councils not to grant permission to employ an assistant. In terms of the regulations a doctor is not allowed to employ an assistant for longer than three months, except with the permission of the Executive Council or, on appeal, of the Committee. (See also 3.)

Proviso (iii) to
Reg. 16 (2).

(i) To consider and determine appeals from doctors against decisions of Executive Councils respecting the extent to which their lists of patients may be increased by reason of the employment of assistants (see also 5). (There is no provision in the English regulations for appeals of this nature. The Minister may, however, direct that the normal maximum number of patients allowed to a doctor shall be increased in respect of the employment of an assistant.)

* Regulation references throughout this document are to the N.H.S. (General Medical and Pharmaceutical Services) (Scotland) Regulations, 1955—S.I. 1955 No. 1942 (S. 148).

Reg. 2 (2) (a).

(j) To consider and determine appeals against refusals of Executive Councils to recognise ostensible partners as partners for National Health Service purposes. A practitioner is not, under the regulation, recognised as a partner unless he is in the position of a principal in connection with the practice, and is entitled to a share in the profits of the partnership which is not less than one-third of the share of the profits of the partner with the largest share. No appeals of this nature have been received. (In England appeals against decisions of Executive Councils in this connection lie to the Minister.)

Para. 1 (k) of
Part II of
First Schedule
to Regs.

(k) To consider and determine appeals against refusals of Executive Councils to pay partnerships on a "notional list" basis. Doctors practising in partnership may have their individual lists of patients calculated notationally, so as to derive the maximum benefit financially from the "loadings" addition to capitation fees in respect of patients between 501 and 1500. Only one appeal of this nature has been received; after a hearing the Committee allowed the appeal. (Appeals of this nature in England lie to the Minister.)

Proviso to
Para. 2 (a) of
Part II of
First Schedule
to Regs.

(l) To consider and determine appeals against decisions of Executive Councils (i) not to make an initial practice allowance available to a particular doctor; or (ii) to discontinue the allowance in the second or third year; or (iii) where the amount payable is in dispute. Appeals of these types can arise only where the Committee have made an allowance available in the district concerned (see (e) above). Three appeals have been made and all were allowed. (The Committee understand that the position in England is somewhat different.)

Reg. 9.

(m) To consider and determine appeals from doctors against refusals of Executive Councils to agree to a proposed exchange of practices between two doctors. No appeals of this kind have been made. (There is no comparable regulation in England.)

2. *Have the Committee formed any impression as to the quality of applicants, particularly as to any changes?*

The Committee do not feel competent to make any comments as to the quality of applicants for vacancies since, as indicated above, the selection of doctors to succeed to vacant practices in Scotland is a matter for Executive Councils. It is only when an appeal is made that the Committee are required to consider the merits of any applicants, and then only those of the doctor selected by the Executive Council and of the appellant(s). It can be stated, however, that generally the doctor selected by the Executive Council is well qualified and has had good experience both in Hospital and in General Practice.

3. *Have the Committee any comments on their experience in dealing with appeals against Executive Councils where the Council has refused permission to a principal to employ a permanent assistant (over three months)?*

The Committee have received only three appeals by doctors against refusals by Executive Councils to allow them to employ an assistant. In one case the doctor decided not to proceed with the appeal; in the second a compromise was reached at the hearing, the Executive Council agreeing to the employment of the assistant for one year provided the assistant was made a partner at the end of the year; and in the third the Committee allowed the appeal. While the Committee have no evidence, they feel that very few principals desirous of employing assistants are refused the necessary permission, Executive Councils usually taking the view that the doctor himself is in the best position to judge whether he requires an assistant.

4. *Do the Committee think there are within the Health Service adequate safeguards against the exploitation of assistants?*

The National Health Service Acts and Regulations do not purport to provide safeguards against the exploitation of assistants, and they do not in fact provide any effective safeguards. Consent is, of course, required before an assistant is employed but the Committee have no knowledge of what criteria are adopted by Executive Councils in granting or refusing consent. A regulation recently made requires Executive Councils to review from time to time all consents given to principals in their area to employ assistants.

5. *Do the Committee think it reasonable that a principal should be able to accept an additional 2,000 patients if he employs an assistant?*

The Committee consider that the 2,000 additional patients allowed where an assistant is employed is high. Even in the most favourable circumstances, e.g., an experienced but active principal, a concentrated practice, and an efficient assistant, a total figure of 5,500 patients for a practitioner and assistant seems too much. One appeal has been received from a doctor to whom the Executive Council refused to allow the extra 2,000 patients in respect of an assistant; in view of the special circumstances of the case the Committee allowed the appeal.

6. *Do the Committee believe any doctors prefer to be permanent assistants?*

The Committee believe that there may be a very few doctors who prefer to remain assistants, rather than accept the responsibility of conducting a practice on their own. But they have no evidence on the subject.

7. *Do the Committee think there would be advantage in their having additional powers to see all partnership deeds and agreements for the employment of assistants?*

The Committee believe that advantage would follow if they had power to see all proposed partnership deeds, and grant or refuse certificates in respect thereof. The probable result would be that in more partnerships than at present the interests of the junior partner would be adequately safeguarded. During the five years to 30th June, 1958, 85 proposed agreements were submitted to the Committee for a certificate under section 36 (9) of the Act. Many of these received a certificate without question: others received a certificate after certain matters prejudicial to the junior partner had been brought to the attention of the applicants or their solicitors, and appropriate alterations made: in the remainder certificates were refused. Appendix VI shows the numbers involved in each category over a period of five years, and also the total number of partnerships that were formed in Scotland in these years.

It will be seen that in 28 of the 85 proposed agreements submitted to the Committee in the last five years (i.e., 33 per cent) the initial refusal of a certificate resulted in the partnership agreement being amended in such a way as to enable the Committee eventually to grant a certificate; and in general the effect of the amendments was to safeguard the interests of junior partners. It is, therefore, not unreasonable to assume that if all proposed partnership deeds had to be submitted to the Committee for scrutiny, a significant proportion of the total number would be adjusted in favour of the junior partner.

As regards agreements for the employment of assistants the Committee believe that assistants are often employed without any written agreement being entered into. Executive Councils are not entitled to require any such agreements to be submitted to them for examination and the Committee do not consider that it should be any part of their (the Committee's) duty to scrutinise agreements of this kind.

8. *To what extent do the Committee effectively refuse entry into closed areas? Do they for instance refuse entry to practitioners who wish to become additional partners? Do they permit the advertisement of vacancies or call for the dispersal of a practice?*

The Committee have never deemed it necessary or expedient to "close" particular areas as the English Medical Practices Committee has done. They have taken the view that every application to enter an area should be individually considered by them, in the light of its own circumstances, and of the conditions prevailing in the area at the time the application is made. Local conditions are, of course, liable to change from time to time, e.g., as regards medical personnel and size of population (which may be affected by industrial or housing developments).

There are, however, one or two parts of Executive Council areas in Scotland from which, in practice, the Committee normally exclude new practitioners—while perhaps granting admission to the medical list for practice in adjacent localities. Whether such exclusion would be imposed in the case of a proposal to practise in partnership would depend on the circumstances of the particular case. (It should be mentioned that a considerable proportion of the applications to join medical lists (and of the refusals of such applications) are in respect of doctors who are on the list of an adjacent Executive Council area, and are desirous merely of extending their practices across the boundary.)

The Committee have no power to stop an Executive Council advertising a practice vacancy, though, in theory, they could prevent a Council filling a vacancy by the appointment of a doctor not already on their medical list, by refusing to admit him thereto. In practice it is unlikely that the Committee would ever wish to object to an Executive Council filling a vacancy in this way. (On the other hand, the Committee have power to require an Executive Council to advertise a vacancy.)

9. *Do the Committee think it reasonable that vacancies in partnerships should, as at present, not be advertised?*

The Committee regard the non-advertisement of partnership vacancies as reasonable, and would not seek to alter the position where a partner is allowed to choose himself the person with whom he wishes to practise. At the same time they recognise that this state of affairs tends to limit severely the number of vacancies—mainly in partnership practices proper, but also, in some measure, in what are truly single-handed practices—which would otherwise be available for open competition. The explanation of the somewhat paradoxical situation whereby a vacancy in a single-handed practice may be, and often is, dealt with under a dispensation designed primarily for partnership practices (in the true sense of the term) is as follows. A single-handed practitioner who is contemplating early retirement on grounds of age or health may assume a partner on the definite understanding that the latter (1) will provide a measure of relief during the period preceding the practitioner's retiral, sharing the profits of the practice on agreed terms, and (2) will, at such retiral, succeed to the entire practice—subject, of course, to the agreement of the Executive Council (which is normally forthcoming). In such a case the practice is a partnership one only temporarily, and during a strictly limited period (which may be quite short and is sometimes curtailed by death); at the expiry thereof it reverts to its normal and recognised state of being a single-handed practice.

10. *Do the Committee think there are sufficient safeguards against the exploitation of junior partners? What proportion of partnership agreements submitted to them are unsatisfactory—and for what reasons?*

See 7 above.

Since there is no obligation on practitioners to submit proposed partnership agreements to the Committee, the existing safeguards under section 36 are not sufficient to prevent or discourage exploitation of junior partners in all cases. As already stated, during the five years to 30th June, 1958, the total number of applications for certificates made to the Committee was 85, i.e., only about 22 per cent of the partnerships formed in the course of these years. (See Appendix VI.) Accordingly, in cases comprising the majority of the total number the Committee were not informed of the terms of partnership, and there was no safeguard against any exploitation of junior partners. The Committee feel that the fact that the demand for partnerships exceeds the supply will tend to increase the risk of such exploitation.)

The chief reasons for agreements being regarded as unsatisfactory were as follows:—

- (a) In the circumstances of the particular case the progression to parity of shares was extended over too long a period.
- (b) Parity was never reached, and the final disparity was either significant in amount or without justification in the circumstances.
- (c) There was a restrictive covenant which would have been a substantial hardship and which was operable against one partner only.
- (d) The junior partner was having to bear an excessive share in the expenses of running the partnership.

It will, of course, be appreciated that, as Appendix VI shows, the initial refusal of a certificate owing to the agreement being considered unsatisfactory does not necessarily result in its being amended and resubmitted to the Committee—although this happens in most cases.

11. *To what extent do the Committee obtain information about a doctor's outside commitments?*

12. *What action is taken where such commitments are large?*

A column designed to show other commitments is provided in the form of annual report submitted by Executive Councils, but in practice the information supplied therein has proved to be of little value. There is, for instance, no indication of how much private practice is undertaken.

Where other commitments were known to exist to a considerable extent, and the numbers on the lists of the doctors concerned were high, a need for additional doctors would be indicated, and the area would be listed by the Committee accordingly.

13. *Would the Committee favour any alteration in the maximum permitted list, either general or in selected areas?*

The Committee do not regard the present permitted maximum of 3,500 patients as any proper indication of the number who can be adequately served—with justice to both patient and doctor. Even in compact industrial areas such a large commitment represents too heavy a burden. The Committee would stress that a reduction to a lower figure should be regarded as a step which must be taken (a) if a satisfactory standard of service is to be provided by practitioners and (b) if the medical profession is to be allowed a reasonable amount of leisure. In expressing this view the Committee are not unaware that financial considerations have a bearing on this question; but they would not seek to intervene in a matter wholly outwith their purview. They therefore confine themselves to putting forward the case for a reduced list, and refrain from expressing any view as to its immediate practicability.

The Committee consider that in determining the optimum list a more than purely statistical criterion requires to be adopted. Substantial differences must be expected to exist between figures appropriate to

sparsely populated rural areas and the larger towns respectively, since in the former case allowance must be made for the greater amount of time expended in travelling. At present, the Committee consider as under-doctored any area where the average number of patients is over 2,500, or 2,000 in areas where other commitments are large, or where a large amount of travelling is undertaken. This leads to the conclusion that the present maximum of 3,500 patients for an individual practice is too high—in any type of area whatsoever.

14. *In considering applications for practice vacancies, what weight do the Committee give to (a) previous experience in general practice and (b) experience of different kinds in the hospital service?*

The Committee have very little experience of considering applications for practice vacancies, since, as indicated above, in Scotland vacancies are filled, not by them, but by Executive Councils. Only when an appeal is made by an unsuccessful applicant for a vacancy are the Committee required to consider the merits of individual applicants; and the number of appeals is few. (See Appendix V.)

15. *Could they give information about the ages at which doctors have in the last few years been appointed to these vacancies?*

The average ages of doctors selected to succeed to advertised vacancies in the five years ended 30th June, 1958 were 36, 39, 34, 37 and 35 respectively, the actual ages ranging from 27 to 57.

16. *Can they indicate over some convenient period what percentage of doctors commencing practice as principals have been registrars?*

The Committee have no information on this subject. As has been explained, they are not called upon to scrutinise applications for vacancies, save to a very limited extent (in connection with appeals).

17. *Could the Committee explain the principles on which they classify the areas of Executive Councils? What figure of patients per doctor results in "closing" an area? What considerations led the Committee to fix the particular figure?*

The Committee do not adopt any rigid classification of areas.

All areas in Scotland are, in theory, open and a doctor may therefore apply to have his name included in the medical list of any Executive Council, every application being considered on its merits. For the convenience of doctors wishing to set up practice the Committee publish a list of areas where they feel that additional principals appear to be desirable. In these areas the average number of patients per principal is in the region of 2,500 or more.

While, as indicated in answer 8 above, no areas in Scotland have been publicly declared "closed," there are two parts of Executive Council areas (residential districts in counties adjoining the City of Glasgow) where the Committee normally restrict the entry of doctors. In one of these districts there are 13 principals with an average list of 1,344, while 45 other principals enter the district, although their main practice lies in an adjoining Executive Council area. In the other district there are 6 principals, with an average list of 1,369, and 134 principals enter from an adjoining area.

APPENDIX I

APPLICATIONS FOR INCLUSION IN MEDICAL LISTS DETERMINED BY SCOTTISH MEDICAL PRACTICES COMMITTEE IN EACH OF THE FIVE YEARS ENDED 30TH JUNE 1958

Type of Case		Year ended					TOTAL
		30th June, 1954	30th June, 1955	30th June, 1956	30th June, 1957	30th June, 1958	
To succeed to a vacancy for which the applicant has already been selected by the Executive Council.	G	43	26	34	19	42	164
	R	—	—	—	—	—	—
To set up new single handed practice.	G	18	9	6	7	11	51
	R	10†	1	3	1	20*	35
To practise in partnership with doctor(s) already on list.	G	82	64	77	59	59	341
	R	1	—	—	—	—	1
To extend existing practice into adjoining area.	G	64	33	61	43	56	257
	R	15	6	1	7	1	30
Total ...	G	207	132	178	128	168	813
	R	26	7	4	8	21	66

G = Granted.

R = Refused.

* 21 Applications were made in response to an advertisement for a doctor to set up a single handed practice in a new town; the Committee granted one of the applications and refused the remaining 20.

† 6 Applications were made in response to an advertisement for a doctor to set up practice; the Committee granted one of the applications and refused the remaining 5.

APPENDIX II

MEMORANDUM REGARDING APPLICATIONS FOR CERTIFICATES UNDER SECTION 36 (9) OF THE NATIONAL HEALTH SERVICE (SCOTLAND) ACT, 1947, IN RESPECT OF MEDICAL PARTNERSHIP AGREEMENTS

1. From time to time applications are received by the Scottish Medical Practices Committee for certificates under section 36 (9) of the Act. Most of these applications relate to Partnership Agreements. Experience in dealing with these applications suggests that uncertainty exists as to the implications of the statutory prohibition of the sale of goodwill; as to the purpose and effect of such certificates; and as to the functions of the Committee in relation thereto.

2. This Memorandum is intended to clarify the position, and to indicate the principles on which, as at present advised, the Committee proceed. In the absence of authoritative pronouncements by the Courts, certain questions must remain matters of opinion. In these circumstances the Committee are guided by such experience as they may possess and by such legal advice as may from time to time be available to them. The views expressed herein are always subject to modification in the light of further experience, consultation and advice, and of the special circumstances of each case.

3. A certificate under section 36 (9) represents the opinion on the Committee. There is no obligation on medical practitioners to possess such a certificate. The

absence of a certificate does not preclude practice, or render a transaction invalid. The sole statutory purpose of a certificate under section 36 (9) is that it may constitute a defence in the event of a practitioner being charged with an offence in respect of the unlawful sale of goodwill. There is no reason to suppose that a practitioner so charged may not justify his action by other means. Moreover, even when a certificate is granted, its value as a defence is entirely dependent upon full disclosure of all relevant circumstances having been made.

4. The Statute provides that any certificate granted shall set out all material circumstances disclosed to the Committee. If all material circumstances have not been disclosed, or if there has been any misrepresentation, the certificate may be disregarded. It is thus in the interests of applicants to make sure that all material circumstances are put before the Committee. The Committee have no duty to discover these matters from their own sources of information. Applications should therefore embody not only the proposed terms of agreement, but an accompanying statement of the circumstances relied upon as showing the absence of any element of unlawful sale of goodwill. Relevant circumstances include all facts tending to show whether there is in fact an existing goodwill which it is unlawful to sell; whether it is intended that such goodwill or any part of it should pass from one person to another; and what are the whole benefits and consideration to be given and received in respect of the transaction. As is hereinafter explained, the age and experience of the parties concerned, and the size and nature and length of establishment of the practice may be of material importance. Merely to submit the bare terms of the proposed agreement can seldom if ever amount to a full disclosure of all material circumstances. If, on the other hand, a full statement of the facts accompanies the application, any certificate granted will be docketed with reference to that statement of facts. It will then be a simple matter for the Court to ascertain whether the certificate was granted after full disclosure and thus constitutes a valid defence, or whether it falls to be disregarded as having been obtained without full disclosure or by misrepresentation.

5. The obligation on the Committee is to grant a certificate only if they are satisfied, on full disclosure, that the transaction in question does not involve the unlawful sale of goodwill. If the Committee are not so satisfied on the information furnished to them, there is no obligation to grant a certificate. Nor is there any obligation on the Committee to specify their reasons for refusing a certificate. Moreover, the Committee cannot undertake in individual cases to offer advice as to what ought or ought not to go into an agreement, or to enter into correspondence on points on which an application is considered unsatisfactory.

6. The Committee are not responsible for ensuring that the terms of any agreement submitted to them are fair as between the parties. Their duty in this connection is simply to express an opinion when they are satisfied that the transaction is free from unlawful sale of goodwill. Indirectly, however, the question of "fairness" may arise. Thus, in terms of the Statute, the unlawful sale of goodwill may take various forms. "Sale" is not limited to the simple passing of money. The offence may be constituted by the giving of consideration in other ways, e.g., by the performance of services. In considering whether a transaction is or is not obnoxious to the Statute, it is necessary to ascertain whether there is a goodwill which it is unlawful to sell. It is necessary to consider whether the agreement contemplates that this goodwill or some part of it may pass from one party to another. It is necessary to consider what consideration is to be given by the party to whom the goodwill may pass; and for what that consideration is being given. Where such consideration is to be given by way of services rendered, and these services do not appear to be compensated by an adequate return (other than the benefit of the goodwill), the inference may arise that the services are to be given partly at least, in consideration for some share of the goodwill.

7. In determining whether the returns provided by an agreement for services to be rendered are adequate (without any element of sale of goodwill) it may be legitimate to start from the basis that equal services *prima facie* deserve equal returns, but in practice the application of this principle must depend on the circumstances of the case. A provision that each partner is to devote full time to the partnership does not necessarily mean that each is making an equal contribution to the earning.

of the partnership profits. Moreover, such factors as age, experience and ability may justly be taken into account. It seems reasonable that where a senior practitioner assumes a junior into partnership, the superior experience, prestige, responsibility and other qualities of the senior may justify an attribution to him of a major share of the partnership returns. But it is to be expected that this "seniority" value should diminish (relatively) as the junior gains in experience and usefulness, and undertakes increasing responsibility. "Seniority value" may justify an inequality of shares of profit in the initial years of a partnership; but there should be a progression towards equality. If the senior partner is an elderly man, a more rapid approach to parity may be appropriate, and it may even be appropriate for provision to be made for the junior receiving a higher share than the senior. Infirmary or ill-health is a factor also to be taken into account. If the assuming partner is little if at all senior to the partner being assumed, no more than a nominal disparity of the shares of profits may be justified, even in the initial stages. While each case must be considered on its merits, any apparently substantial over-assessment of "seniority value" may well be tantamount to the sale of goodwill, unless it can be shown to be justified on other and specific grounds.

8. If it is the intention of parties that there should be a progression towards parity or near-parity, this should be provided for expressly. If this is not expressly provided for, provision should be made for periodical review. Such review may be operated by way of arbitration; and if this is the intention, it should be made clear that the arbitration clause is not confined to a mere interpretation of the agreement, but authorises the arbiter to make such a review.

9. Some of the partnership agreements submitted to the Committee include restrictive clauses. In the past, such clauses were usually framed so as to restrain an outgoing partner from competing during a specified period from the date of dissolution. In agreements entered into before the appointed day, this was no doubt perfectly proper; for it was then legitimate for parties to make their own bargain on terms which allowed the possessor of an established goodwill to sell it, or to buy it back at the termination of a partnership, and to protect it as a valuable asset after the dissolution. It may be questioned how far such provisions are justified in agreements entered into after the appointed day. But where a restrictive covenant is provided for, it undoubtedly constitutes one of the elements entering into the consideration given and received. Accordingly, in assessing whether the consideration given and received under an agreement is fairly equated to the returns (and may therefore be assumed to be innocent of any element of sale of goodwill), it is important to ascertain what the effect of the restriction may be in all the circumstances in which it may operate. If a restrictive covenant is so framed that its operation may in any circumstances deprive a partner of a fair return for services rendered, this may give rise to the inference that the restriction is being accepted, in part at least, in consideration of his being admitted to a share of the goodwill. Particularly if such a restriction is framed so as to be operable against one partner only, and not all, the inference may be manifest that it represents an exploitation of goodwill tantamount to sale.

10. It may be contended that during the period when a newly-assumed junior partner is obtaining the benefit of introduction to established patients, it should be open to the senior to protect his legitimate interests by a clause which restrains the junior from unfairly attracting those patients to himself in the event of his choosing to sever the partnership. It is suggested, however, that such protection may be sufficiently assured by a clause designed to operate over a period starting, not from the date of dissolution of the partnership, but from the date of assumption of the junior partner concerned. It is felt that once the junior has reached the stage of substantial contribution to the work of the partnership, and a state of mutual confidence has been achieved, protection by such a clause is no longer necessary, and is not easily justifiable. Care should therefore be taken to ensure that any restrictive covenant is so framed that, taken by itself or in conjunction with other clauses, it is not inconsistent with the statutory prohibition of sale of goodwill.

11. The foregoing Memorandum has been drawn up as a general guide. *Mutatis mutandis* it may be applied to the case of multiple partnerships, or other forms of agreement. But each case falls to be decided on its merits, and in the light of its own particular circumstances.

APPENDIX III

INITIAL PRACTICE ALLOWANCES

(This Memorandum was issued by the Committee to Executive Councils.)

1. The Committee think it might be helpful to Executive Councils if they stated the main considerations which at present they take into account in determining whether or not a particular part of an Executive Council area should attract one or more Initial Practice Allowances. Most Executive Council areas are, of course, too large to be treated as a whole for this purpose; it is therefore the Committee's practice to break down these areas into appropriate districts, and consider each by itself.

2. The first consideration to which the Committee direct their attention is the average number of persons per doctor. But it is obvious that taken by itself this could be misleading. It is necessary to take account at the same time of such factors as type of practice, age of doctors, size and geography of district, total population, and distances to be travelled by doctors.

In any district where the average number of patients on doctors' lists is over 2,500 a new practice would normally be regarded as eligible for an Initial Practice Allowance unless the introduction of even one doctor would excessively reduce the average list. Where, however, the average list is under 2,500 but over 2,000 the question could only be determined after a careful scrutiny of the various factors mentioned above. Exceptionally a district with an average list of less than 2,000 might call for consideration on the same basis.

3. It is always open to any Executive Council, after reviewing the conditions prevailing in the different parts of their area, to recommend to the Scottish Medical Practices Committee that an Initial Practice Allowance should be made available for a particular district whether or not they have before them a definite application for such an Allowance from a practitioner. Any such recommendation would receive the careful consideration of the Committee who would inform the Council of their decision as soon as possible. The Council would then be in a position to inform any enquirer whether or not a new practice would carry an Initial Practice Allowance, it being clearly understood that any decision of the Committee approving such an allowance was conditional on no change of circumstances taking place subsequently.

APPENDIX IV

VACANCIES DEALT WITH BY EXECUTIVE COUNCILS IN SCOTLAND IN EACH OF THE FIVE YEARS ENDED 30TH JUNE, 1958

Method of dealing with vacancy	Year ended					TOTAL
	30th June, 1954	30th June, 1955	30th June, 1956	30th June, 1957	30th June, 1958	
Filled by introduction of new doctor after advertisement ...	26	18	25	13	30	112
Filled by introduction of new doctor without advertisement ...	4	2	3	1	1	11
Filled by introduction of new partner ...	13	7	7	9	16	52
Not filled						
(i) Patients transferred to list of other doctor in area* ...	29	30	32	32	45	168
(ii) Patients advised to select a new doctor for themselves ...	23	20	11	16	8	78
Total ...	95	77	78	71	100	421

* In most cases the doctor (or doctors) to whom the patients were transferred was an existing partner of the resigned or deceased doctor.

APPENDIX V

APPEALS BY UNSUCCESSFUL APPLICANTS FOR VACANCIES DEALT WITH BY SCOTTISH MEDICAL PRACTICES COMMITTEE IN EACH OF THE FIVE YEARS ENDED 30TH JUNE, 1958.

		Year ended					TOTAL
		30th June, 1954	30th June, 1955	30th June, 1956	30th June, 1957	30th June, 1958	
Number of Appeals determined after Hearings.	A	2	1	—	1	1	5
	D	1	—	—	4	5	10
Number of Appeals determined summarily.	A	—	—	—	—	—	—
	D	8	3	7	7	1	26
Number of Appeals withdrawn before decision was reached... ..							
		2	1	2	—	—	5
Total ...		13	5	9	12	7	46

A = Allowed.

D = Dismissed.

APPENDIX VI

Table showing the number of applications for certificates in respect of partnership agreements made to the Scottish Medical Practices Committee under Section 36 (9) of the National Health Service (Scotland) Act, 1947, the results of these applications, and the total number of partnerships formed in Scotland in each of the five years ended 30th June, 1958.

Decision of Committee	Year ended					TOTAL
	30th June, 1954	30th June, 1955	30th June, 1956	30th June, 1957	30th June, 1958	
Certificate granted immediately ...	10	5	10	11	4	40
Certificate granted after amendment made to the agreement ...	8	5	4	5	6	28
Certificate refused ...	4	1	7	2	3	17
TOTAL APPLICATIONS MADE ...	22	11	21	18	13	85
TOTAL NUMBER OF PARTNERSHIPS FORMED ...	95	71	84	68	75	393
Proportion of total number of partnerships in which applications for certificates were submitted ...	23 %	16 %	25 %	26 %	17 %	22 %

Examination of Witnesses

DR. J. T. BALDWIN, *Chairman*

MR. A. I. MILLAR

MR. J. MCCALLUM, *Secretary*

MR. A. B. FAIRWEATHER, *Former Secretary*

on behalf of the Scottish Medical Practices Committee

Called and Examined

5195. *Chairman*: You will appreciate, I am sure, that as we have been sitting for a long time now and have a great deal of evidence, we may consider some of the ground covered in your memorandum to be outside our terms of reference, but there are certain particular matters on which you can help us.

We have allocated the job of preparing for this particular hearing to a sub-committee, of which Sir Hugh Watson has been acting as Chairman, so he will be asking you most of the questions. However, any of us may chip in and we want you to feel perfectly free to answer in turn. Who is to be the principal spokesman for the Scottish Medical Practices Committee?—(*Dr. Baldwin*): I am.

5196. Would you care to start, Dr. Baldwin, by telling us the terms of reference of the Committee, if there are any, as distinct from their duties? By whom are you appointed?—We are appointed by the Secretary of State.

5197. Direct?—In the National Health Service (Scotland) Act, 1947, paragraph 35 (2), it says: "With a view to securing that the number of medical practitioners undertaking to provide general medical services in the areas of different Executive Councils, or in different parts of those areas is adequate the Secretary of State shall constitute a Committee, to be called the Scottish Medical Practices Committee, for the purpose of considering and determining applications". It then gives details of the constitution.

5198. Is the Committee partly lay and partly medical?—Yes, Sir. The Chairman of the Committee is required to be a medical practitioner, and there are three medical practitioner members, all of whom must be in active practice. The Chairman, himself, does not need to be, but always has been. There are also two

lay members, one of whom is an advocate and the other, Mr. Millar here, is a layman who has a wide knowledge of National Health Service affairs.

5199. *Sir Hugh Watson*: So that you do not, in fact, have any terms of reference, except what is provided in the Act?—That is so.

5200. And the Act lays down the duties which you are to perform, which you set out in your memorandum under paragraphs 1 (a) to (m)?—Yes.—(*Mr. Millar*): The Act, itself, specifies one other duty which we have got to perform, and that is to give certificates for partnership agreements. All of our other functions are imposed on us by regulations made by the Secretary of State.

5201. In your paragraph 2 you say that you do not feel qualified to make any comments on the quality of applicants for vacancies. But you do have some contact with these applicants. As we understand it, you have to deal with people who appeal against the decision of the Executive Council in connection with an appointment to a vacancy. You have the last word, do you not?—(*Dr. Baldwin*): Yes.

5202. And, similarly, those who are entering a partnership by agreement with the other partners come under your scrutiny?—An application to join the medical list is received by us from every practitioner wishing to join the list, but we do not necessarily have any personal contact with these applicants; in fact, in the majority of cases we do not see them at all.

5203. So you would not know very much about them, really?—Not really.

5204. In your paragraph 2, you say that generally the doctor selected has had good experience both in hospital and in general practice. What is your Committee's view of the value of hospital experience in general practice?—

If I may make a general statement, I would like the Commission to appreciate that I am only part-time Chairman of the Scottish Medical Practices Committee. I have other functions in the National Health Service, and I may find myself speaking rather from the point of view of a practitioner. It is difficult for me sometimes to separate that.

5205. *Chairman*: That will still be of great help to us. I do not think we mind in what capacity you are speaking. —We attach a considerable amount of value in general practice to hospital experience. We would regard it as necessary and, in any case, the Medical Act now requires a graduate to have a year's hospital experience after graduating before he becomes a registered practitioner. We feel that the probability is that he would be much better if he had even a little more hospital experience. On the other hand, we feel that he could have too much hospital experience for entering general practice. For example, if he continued in his hospital experience, it is more than likely that his experience would become channelled into a specialty, and if it were one of the less common specialties it might well be of little use to him in general practice; for example, neurosurgery, thoracic surgery, or something of that kind. On the other hand, if he had an additional appointment in obstetrics it would be of the greatest possible value.

5206. *Sir Hugh Watson*: I think we have had exactly that expression of opinion elsewhere. So, generally speaking, your view would be that it would not be of advantage in general practice for a person to pursue a specialised line in hospital? —That is so.

5207. But if he could study further in hospital some particular line which would be of use to him in general practice, such as obstetrics, that would be a good thing? —Yes.

5208. *Chairman*: What you actually mean in your paragraph 2, when you talk about having good experience both in hospital and general practice, may very well be just one year or 18 months as a House Officer? —Yes.

5209. *Sir Hugh Watson*: You are a member of an Executive Council? —I am, Sir, yes.

5210. Would your experience as a member of an Executive Council lead

you to suppose that Executive Councils undervalue hospital experience? —I do not think they do.

5211. We have had a lot of evidence to the fact that it is difficult to go from one branch of the profession to the other, except in the very initial stages. It is difficult for people to get from the hospital service into general practice and vice versa. —Yes.

5212. You accept that that is the position? —Yes I do, indeed, and further than that it is difficult, having once obtained a post in general practice, to obtain another one. It is difficult to move even from one medical practice to another medical practice, within the same branch of the service.

5213. Yes, that is another point. But we have had evidence that there is a certain rigidity, almost, as between the two branches of the profession. —Yes, that is so.

5214. Do you think that is a good thing? —I think it is too rigid.

5215. How would you suggest that that could be improved? —It is difficult to say. We have not given great thought to it, but I think one thing which would be of advantage would be if, for example, general practitioners had opportunities to take hospital appointments as clinical assistants, or whatever you care to call them, where they would have an opportunity of working with consultants, in order to obtain experience which would enable them to take additional qualifications.

5216. *Chairman*: We are, of course, very much on the remuneration point. Are there any features of remuneration that make it particularly difficult for anybody to pass from one branch to another, from general practice to hospital service, or vice versa? —As far as the present remuneration structure is concerned, you mean? There is no theoretical difficulty or theoretical reason why a general practitioner should not undertake an appointment outside general practice. He can still act as a general practitioner and can contract with the local Executive Council and take an appointment in the hospital service, assuming it is a part-time appointment. But I have no knowledge of the working in the opposite direction, as to how possible it is for a person employed in the hospital service to obtain general practice experience.

5217. The point I was getting at was are the levels of remuneration at these sorts of ages in the two branches of the profession near enough in balance for it not to be a great deterrent for somebody to move from one to the other?—I do not think I can give an authoritative opinion on that, Sir.

5218. *Sir Hugh Watson*: I am not quite sure what is the right place to bring in the next point, but probably this is as good a place as any. We have been told about trainee assistants, but we have not heard very much about them, really. Can you tell us, in the first place, how the trainer doctor is chosen?—Yes, Sir. In Scotland the procedure is different from that which obtains in England and Wales. In Scotland there is in each region of the National Health Service a Committee appointed to select trainer practitioners. In the South-Eastern Region, the region with which I am familiar, the Committee consists of a Chairman, who is a layman, and members who are general practitioners, appointed by the Secretary of State but nominated by the Local Medical Committees; also, representatives of the consultant service, whom I presume are also appointed by the Secretary of State. They meet in this area twice every year to consider applications from practitioners to be appointed as trainers. There is a memorandum which lays down the criteria which the Committee use in considering whether the practitioner should be regarded as a trainer. These, I may say, are such that, broadly speaking, it is considered that if a practitioner has a practice of such a size that he is likely to be very busy, he is not considered to have the time to train an assistant. Therefore, a practitioner in an urban area who has more than 2,500 patients, or in a rural area who has more than 2,000 patients, is regarded as having a practice which is too large to enable him to devote time to the training of an assistant. The applications are made on a form which goes to the Secretary of the Committee. They are submitted to the Committee, and I can safely say that each applicant is known to several members of the Committee, personally. General practitioner representatives on the Committee as a rule know the applicants to a certain extent. We have valuable help, also, from the consultants who are very well

aware, as you know, of these practitioners' qualifications as practitioners, and as likely trainers. Does that help you, Sir?

Sir Hugh Watson: Yes, indeed. We did not know anything about that at all.

5219. *Mr. McIntosh*: And what is the practice in England and Wales?—I am open to correction on this, but I understand that in England and Wales the Committee is basically the Local Medical Committee, and there are certain University representatives or consultant representatives, or something of that kind, but the Local Medical Committee is the principal unit.

5220. But with the same criteria?—I do not know about that.

5221. *Chairman*: Do the same doctors normally go on being trainers year after year?—They go on often for several years, but it is the practice in the South-Eastern Region, which is the only one that I know about—but I believe there is a similar practice in other regions—to consider that after a period of four or five years the trainer should have a rest from training; and in any case the practitioner is not appointed for several years in succession, if there are other suitable practitioners who are available to act as trainers. It is generally regarded as desirable that, after a period of at most five years, a practitioner should have at least one year break.

5222. Is it, in fact, a mark of being a rather good doctor to be chosen as a trainer?—Yes, Sir.

5223. *Sir Hugh Watson*: What induces a doctor to apply to be a trainer?—I do not know. It is very difficult to say that. I should think it is difficult to escape the view that he feels he may get a little help. It is almost certainly the case that he does not need help.

5224. Because he has only got at the most 2,500, or 2,000 in a rural area?—Yes. In the practice in which I am a partner, my senior partner is a trainer practitioner and has been for some years, and we have found it quite a stimulating thing for us to be trainer practitioners. We learn a tremendous lot from the trainee, and I understand that the trainees have been satisfied with their training and they tell us that they have learned from us, too. But the curious

thing is that when our turn came to be without a trainee we found we were, perhaps, a little less busy when he was not there, than when he had been there.

5225. *Chairman*: Is the trainee appointed to a practitioner, or to a partnership?—To an individual practitioner.

5226. And more often than not will it be a practitioner in a partnership or single-handed?—Speaking from memory, I should say about half and half.

5227. *Sir Hugh Watson*: Is the scheme largely taken advantage of?—In the South-Eastern Region there are always more applications to be trainers than there are training practitioners.

5228. I meant it the other way.—You mean so far as the assistant is concerned?

5229. Yes.—No, not as much one would have thought. It is well known that it has been difficult to get a trainee over the past year or two, and I know that in some parts of the country it is more so than others.

5230. Do you think that the scheme is a good scheme?—I do, indeed.

5231. You think it is better than just turning a young doctor loose as an assistant?—It is difficult to say that. I think that the essential reason why the trainee scheme is a good scheme is that there is no doubt in my mind that the way an assistant in general practice starts his work—that is to say, the kind of practice that he finds himself in—is what will influence his way of practice during the rest of his professional life. I am sure that there is some reason for that statement, and, if that is the case, if he gets into a good practice to start with then he is likely to be a good doctor in the future. But there is no doubt that there are practices in which the kind of training is not all that could be desired.

5232. *Mrs. Baxter*: If a trainee assistant is taken on he stays there for one year?—Yes.

5233. If he enters as an assistant to a partnership, there is no necessity for him to leave at the end of the year, so he is likely to stay?—He can stay there as long as he is offered the post.

5234. So entering as a trainee assistant, does the young man get experience of at least two practices?—Yes. You mean

that he has his year as a trainee, and thereafter he goes elsewhere?

5235. Yes, and thereafter would he go as an assistant, or would he be likely to get a partnership straight away?—It varies a great deal. Ordinarily, he would not get a partnership straight away—it is unusual for a doctor to go straight into partnership. It is customary for him to undertake a preliminary period of assistantship, even if it is not a very long one. On the other hand, I know some trainee assistants who, after their training year, have felt certain shortcomings, having been in practice; they feel they would prefer to take up a hospital appointment, and they have gone back to hospital appointments for six months or so, and have then again entered practice as an ordinary assistant.

5236. *Chairman*: Is there difficulty for someone who has just finished his job as a trainee assistant, in finding a full genuine assistantship?—There is some difficulty. The difficulty is not so great as it is sometimes made out to be. I think that the difficulty is very often due to the fact that an assistant wishes to restrict the area in which he practises. In my own practice we have had experience of that kind. An assistant, an able man, wished to practise within the Edinburgh area and he found some difficulty in getting a place that suited him. Another one, who was prepared to go anywhere, obtained a partnership in a very short time in the North of England in an industrial practice.

5237. *Sir Hugh Watson*: In your Appendix I we notice that, on the average of the five years given there, only about ten doctors have set up single-handed new practices. Would that be a large figure, do you think, or a small figure?—I do not know whether I can say if it is a large or a small figure, Sir. I have no idea what sort of percentage of doctors, before the National Health Service, set up a new, single-handed practice, so I do not know whether the numbers are declining or not. I think the tendency will be for them to decline.—*Mr. Fairweather*: Single-handed practices have been declining, particularly since 1953, when the new arrangements about payment for partnerships were introduced.

5238. There are three ways of getting into general practice, as the Commission understand it. You can succeed to a

practice vacancy, you can become an assistant, or you can put up your plate, which is the one we are talking about at the moment?—Yes.

5239. And we understand that the method which is normally used is for a doctor to become an assistant, and then become a partner?—*Dr. Baldwin*: Yes, indeed.

5240. In Scotland you do not have designated areas, as they have in England?—That is so.

5241. But the Executive Councils and the Medical Practices Committee know very well the areas which are very well doctored, and while they do not have these English classifications, in practice the thing works pretty much the same way, I suppose?—I think it does, in a way, except that if in Scotland we adopt the practice of English Committees, the areas which would be classified as closed areas would be very few.

5242. Having that in view, what do you think about this figure of 10 people who put up their plates?—There is a difference between an area which is adequately doctored, and one which is very much under-doctored. We prepared a table which indicated the success of practitioners setting up a single-handed practice with an Initial Practice Allowance. It was a very instructive table, and showed that, generally speaking, the only likelihood of a practitioner putting up his plate and meeting with success—that is to say, building up a practice within three years, in which he could earn his living—would be if he were in practice in a newly developing area, where new houses were going up and people were coming in. In an already developed area, where there were already practitioners practising in the area, his likelihood of practising by ethical means and attracting to him enough patients to make a living in that range of time was very remote. The average person is not prepared to change his or her doctor.

5243. *Chairman*: In the light of that, would you think that 10 new practices a year was not bad?—I would say it was not so bad. Mr. Fairweather has a graph, which he can show you.

5244. *Sir Hugh Watson*: For the record, Mr. Fairweather has produced a

graph* which shows, with a dotted line the number of applications from doctors to practise in partnership.—*Mr. Fairweather*: And with an unbroken line it shows the number of applications to practise single-handed. You will see how the partnerships shot up in 1953 at the time of the new award.

5245. The applications for single-handed practices never rose more than about 10 in a year?—Yes, that is so.

5246. In 1953 the applications to practise in partnerships rose to very nearly 60; in general they appear to be running at about 25 to 30?—Yes. Actually, these are not yearly but quarterly intervals. That point of 60 you mentioned was in respect of one quarter.

5247. It goes to a peak after the alteration that you have been talking about?—Yes.

5248. *Chairman*: It does seem that in the same quarter as you had this great peak of partnership applications, you had a peak of single-handed ones. The tail-off has been to about 2 or 3 compared to 15 to 20, of course?—Yes.

5249. *Sir Hugh Watson*: You referred just now, Dr. Baldwin, to the Initial Practice Allowances. Do you think these allowances are achieving the purpose for which they were intended?—*Dr. Baldwin*: This is a personal opinion, but I think that they do so only in those cases where a practitioner enters a newly-developing area, in which there are a large number of patients. I should say that, in order to succeed in its purpose, the Initial Practice Allowance in an area where there were not a lot of new patients coming in would require to be tapered off much more slowly.

5250. In other words, it would take the practitioner much more than three years to establish himself?—Yes, and the third year's allowance is very meagre if he is not attracting patients.

5251. Applications for these allowances are made to your Committee?—After having been to the Executive Council who, with the Local Medical Committee, consider them and make recommendations to us.

5252. Can you tell us the criteria which govern the consideration of these applications?—Yes, Sir. Very largely, the criteria which we use in considering

whether an area is in need of an additional practitioner are in the document which we have submitted to you, but there are other factors, too. We consider each case on its merits. We receive from the Executive Council the names of practitioners practising in the area—if there are any, and there usually are—and the numbers of patients on their lists and their ages. There are also other considerations which we sometimes take into account, such as special conditions relative to the particular district. It may well be that it is considered desirable that a particular practice should remain as an entity, in which case the Initial Practice Allowance may be given to encourage a practitioner to start there. There might be possibly the case of a practice where it was felt desirable that a woman's practice should be maintained in an area, and that might be an additional reason. These are special reasons, but you will notice that we consider certain figures and numbers of patients.

5253. Are many of these applications refused in practice?—No, not many are refused. I think that the Committee will sometimes wonder whether they will result in a practitioner being able to establish himself, but as a general rule applications are not refused.

5254. Turning to another subject, we have had some suggestion, without anything very definite being put before us, that in some quarters there is a tendency to exploit assistants. Naturally, that evidence has come mostly from the assistant side of the profession. You have sometimes refused permission for the employment of an assistant?—Very, very rarely indeed, Sir. It has not been done since I became Chairman of the Committee.

5255. On what grounds would you consider that a Committee would be liable to reject such applications?—Perhaps Mr. Millar, who has had some further experience, could tell us that. He has been a member of the Committee longer than I have.—*Mr. Millar:* We have had very few of these cases, but one curious aspect which one finds is that the reason an Executive Council has refused consent to the employment of an assistant is often that they think that the practitioner should have another partner rather than an assistant, so they try to exercise pressure on him to take in a partner. Of course, this is rather

a difficult situation, because we have no power to force a doctor to take a partner, and if he is determined not to take a partner and wants an assistant and nothing else, then if he is refused the assistant he is left with no assistance at all, and that is not so good for the patients. So it is sometimes difficult to know how to handle cases. One has to take the interests of the patient into account, and if one is going to be swayed by that aspect, one gives consent to the employment of an assistant as being better than nothing.

5256. Yes, but what you are saying very nearly comes to the fact that there are quite a number of cases in which the Executive Council think that the doctor should not, in fact, have an assistant; he ought to have a full partner.—That is so.

5257. Which would almost confirm the view that assistants, if not exploited, are made use of in circumstances where they should not be made use of.—Yes, I should think that is a correct statement of the Executive Council's feelings in the matter.

5258. In all the circumstances, does the Committee think that assistants should be employed, and that it is permissible to employ or reasonable to employ assistants?—*Dr. Baldwin:* My personal view in this matter is that if a doctor thinks he should employ an assistant, and is prepared to pay his salary out of his own pocket, there is no reason why we should interfere.

5259. There is, of course, no scale of salary laid down for an assistant?—That is so.

5260. There is a scale for a trainee assistant, but there is no scale for an ordinary assistant?—Yes.

5261. Do you think that circumstances as they are give any reason to suppose that there ought to be such a scale laid down, or does the market find its own level?—I think that, generally speaking, the market finds its own level. I think there is no doubt that the scale laid down for a trainee assistant has proved to be some sort of a guide. It is most unusual for an ordinary assistant to be remunerated except at a little higher level than the trainee assistant. But, generally speaking, I think that the assistant's salary is probably fair, at least in the initial stages.

5262. *Mrs. Baxter*: Is it on an incremental scale?—The assistant's salary is entirely a matter of arrangement between the assistant and his principal. I think, generally speaking, it is true to say that, in a good class practice, if an assistant has been there for a year and stays longer, he gets an increase in his remuneration; and he would ordinarily not expect to stay more than two years, because he would either become a principal, or leave for a more permanent post.

5263. *Sir Hugh Watson*: We have had evidence from some professional bodies, who go so far as to say that in their view they can hardly conceive of circumstances in which a doctor should be allowed to employ an assistant.—It would seem to me that there should always be a place for an assistant in general practice. It has been recognised for a long time that the best way to get into practice is to become an assistant. I say to the trainee practitioners who come to us "Take an assistantship without a view to partnership, and you will find that a practice will come to you." I say that that is as good a way as any, provided they choose the right area.

5264. We have heard a lot about the difficulty of getting into general practice, and what you have said is very interesting. Does your experience bear out what you have prophesied to these young men?—Yes, Sir. I think in each case all the assistants we have had, with one exception who is in a different class from the others, have established themselves quite soon permanently in practice. They have all been assistants.—*Mr. Millar*: And eventually they become partners.—*Dr. Baldwin*: Not all of them. One of them got an I.P.A., and set up in a new housing area. But they have all succeeded.

5265. *Mr. Gunlake*: Where you encounter, as you say you have, a certain reluctance in some cases to take a man into partnership, have you any reason to suppose that the reluctance is on purely financial grounds? Or would you take the view that the relationship as between partner and partner is a rather complicated relationship and it does not necessarily follow that a man, who is acceptable as an assistant, would be acceptable as a partner in those wider

senses?—I am sure you are right in this. There are two factors. I know of principal practitioners in single-handed practices, who do not wish to take a partner for personal reasons, and there are assistants who are content to be assistants, although there are not many of these. But the personal factor is a very important one.

5266. *Chairman*: Do you know of many cases where a practitioner takes as many as ten assistants in succession, or anything like that?—I do not know of any case of that kind and, in my experience in the south-east of Scotland, I cannot think of any practitioner who has taken a large number of assistants.

5267. They do in the end, having had a fairly small number of assistants, go and take an extra partner?—Not necessarily. There is this other curious position in which a practitioner may, in his later years in practice, take an assistant for a few years, and finally take him into partnership for the purpose of allowing him to succeed to the practice. He then retires and the practice remains a single-handed practice, which is rather a different position. But I do not know, in my own area, of any practice which would be regarded as one which is always run with an assistant.

5268. *Sir Hugh Watson*: So much for the assistants. Could we look for a moment or two at the position of junior partners? In your paragraph 7 you tell us something about the partnership deeds which have come before you, the number that you have had to get altered, and so on. Would it be reasonable to assume that the agreements which are submitted to the Committee are on the whole less likely to be open to criticism than the ones which are not submitted?—I do not know, Sir. We have no means of knowing. It is possible that what you say is true. On the other hand, I am entirely satisfied that there are practice agreements which do not come to the Committee and which are perfectly good.

5269. Is it possible that there are cases where a senior practitioner puts pressure on a junior to accept an agreement which is not as favourable to the junior as it might be, and which is not put forward to your Committee?—I think that is the case.

5270. *Chairman*: Would many of the agreements which do not come to your Committee simply be virtually a copy of

a perfectly satisfactory agreement applying to a new partner terms that have applied to others in the past?—I should think so. There is no reason for us to believe that, of the agreements which are not submitted, any greater percentage of them would not be acceptable, than those which are submitted.

5271. *Sir Hugh Watson*: Is the practice of going into partnership now becoming more general?—Yes, there are more partnership practices than there were.

5272. And, by and large, are doctors becoming accustomed to the adjustment of reasonable partnership agreements?—Yes, I think so. There is quite a lot which we do not know. There are a large number of agreements which we never see. One has seen agreements which are quite shocking.

5273. You have told us in your memorandum that it would be an advantage if you could see all partnership agreements.—It would be an advantage to the junior partners, on the whole.

5274. And if it were recognised as standard practice that all agreements should be submitted to you, then nobody could have any ill-feeling about it?—That is so, I think.—*Mr. Millar*: I think one has to keep in mind the purpose of the statutory provision on this matter. It is not to protect the junior partner, of course; it is to protect the senior partner, usually, against the possibility of being charged with an offence under a Section of the Act.

5275. Yes, of course. You mean for the sale of goodwill?—It is a purely voluntary act on his part to come along, and he does it for his own protection. It might be wrong to force our services, so to speak, on people who could get along quite well without them. On the other hand, if it were decided that it was a good thing that the interests of junior partners should be protected, then the Act should be framed differently and it should set out plainly to achieve that object. Another object, which might be thought to be secured by the oversight of all agreements, is to secure that the law is observed in this matter, instead of relying on the authorities to prosecute any offenders. It might conceivably be provided that an agreement would not be legal unless it was submitted. It all depends on what is your objective. It might be one of these things.

5276. I am much obliged to you for pointing out what is the real object of the statutory provision. It is, of course, to make sure that there is nothing in the nature of a sale of goodwill.—Yes, it is to protect the senior partner, if he desires protection, against the possibility of being charged. He may say "I am quite well able to look after myself, and I have every intention of giving my junior a square deal. I am quite sure that the terms of my agreement will secure this square deal, so there is no need for me to submit the agreement."—*Dr. Baldwin*: The advantage to the junior partners is incidental, but very real.

5277. But on occasions you have intervened to improve the position of the junior partner?—Yes, indeed. We have intervened to prevent the agreement infringing the Act, and by so doing it has been to the benefit of the junior partner.

5278. Turning to another point, when your Committee are considering the number of doctors in an area, and whether it is under-doctored or otherwise, what if any information do you have about the private commitments of a doctor outside the National Health Service?—In the form which is prescribed, local Executive Councils set out the numbers of doctors, the numbers on their lists, the mileages and so on. There is a column which asks for hospital or other commitments, and in many of these Executive Council reports this column is blank. We do not really know, as a rule, what other commitments general practitioners have. We have no reliable information as regards their private practice.

5279. It was the private practice which I was really after.—We therefore pay no attention to it whatever, because any information that there is is undoubtedly not reliable, and we feel that it is perhaps unrealistic to pay attention to some information which we receive from one Executive Council area, whereas in another area, where we have reason to believe there may well be other commitments, there is no information given at all. It is extremely difficult to obtain this information.

5280. Yes, we know that. That is why I asked the question.—I do not know how you will do it.

5281. *Mr. Gunlake*: What do you regard as an area, for this purpose?—

I refer to my own area. The area that I am speaking of now is the Lothians and Peebles Local Executive Council area, which is the area in which I live and practise, and which consists of the three Lothians and the County of Peebles.

5282. I was thinking of the average. —When we are considering this question we receive information from each Executive Council, and each Executive Council area is usually divided by the Executive Council.—*Mr. Millar*: Scotland is a comparatively small area, and most of us have a fair idea of the different parts of the country, and the characteristics. We also know—and we are, of course, assisted by the reports—which doctors are serving roughly which districts. For example, in a large burgh we would look at the doctors practising in the burgh. They might have a few patients outside, or there might be some country doctors coming in, but by and large we would look at the doctors who have surgeries, and whose residences would usually be, within the burgh.

5283. *Sir Hugh Watson*: So the answer is really that it is very difficult to know what are the outside commitments of the doctor?—*Dr. Baldwin*: Yes.

5284. Next is a somewhat controversial and rather difficult question. You give us certain views about what is the proper size of the list. It is very difficult to be dogmatic about that.—Yes, Sir.

5285. The maximum has been reduced to 3,500 now?—That is so.

5286. Is the position really that so much depends upon the ability, the personality, the methods of the doctor himself, and the nature of the area, that it is almost impossible to generalise?—I think that is probably true. I know from my own experience, in my own area, one practice of two partners with a total list of 2,000 who asked permission to employ an assistant. I also know of another practice where a single-handed doctor has 3,500 patients and is recognised as one of the ablest practitioners in the area; his organisation is first-class. You also have everything in between.

5287. *Chairman*: The maximum list, whatever is the maximum, being an extreme must relate to extreme conditions, and has little relation to the

normal?—I think so. The other alternative is to bring the maximum down to the average, which would be most undesirable.

5288. *Sir Hugh Watson*: The next point is the question of inducement payments. In the remote areas of Argyle, Inverness, Ross, and so on there are inducement payments?—Yes.

5289. Do you find that these are working?—I think they work extremely well. I think there are 47 inducement payments made in Scotland in the National Health Service, and they are indeed working very well. There is no doubt whatever that, in many of these areas, there would be no practitioner without the inducement payment, which may be very substantial.

5290. Your Committee advise the Secretary of State about these payments?—We do indeed, yes.

5291. Could you tell us something about the circumstances which warrant your recommending the Secretary of State to make such payments?—There are two principal features. First of all, it is necessary for the practice to be maintained, in order to provide a medical service to the people, and in order to do that it is desirable to provide that the doctor shall earn an income which will enable him to live. If his circumstances are such that, by virtue of the small number of patients, for example, it is not possible for him to do so, then he must be paid an additional sum of money to enable him to make a living. We have at least one example where the expenses of the practice are in excess of the income, and therefore it is necessary for a substantial inducement payment to be given, to enable the doctor to exist at all.

5292. From what you have said, it would appear that the amount of the payments in various cases may vary considerably?—Indeed, that is so. There is a figure; it is not entirely adhered to, because it is difficult to justify a fairly substantial income to a man who has, perhaps, 200 patients. The earnings must relate to some extent to his amount of work, but there is a figure of, I think, £1,600, which is regarded as the net income which it is desirable to achieve, but he does not always achieve that.

5293. In this paper you have passed to me there are inducement payments shown of £473, £1,292, £340, £1,022 and so on.—Yes.

5294. *Chairman*: For instance, in an area such as you mentioned where the expenses exceeded the possible gross income, to get a net income of £1,600 you will have to pay something in excess of £1,600?—Yes. This is one of the islands in which there must be a doctor, and there are about 170 patients.

5295. And in most of these cases does income from dispensing help a bit?—Very little, because there are so very few patients. Any income is taken into account, and we get a flat statement of income and expenditure from the Department, when we are asked to give

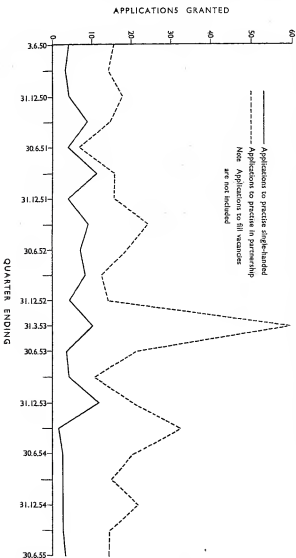
our observations on how much it should be.

5296. As a system, you really have no alterations or recommendations to suggest, so far as remuneration is concerned?—No. So far as I am aware it works very well.

5297. *Chairman*: I think we have covered your memorandum. I will just ask if any of the other members of the Commission want to ask any questions. Is there anything additional which has occurred to you, since you submitted your memorandum?—No, Sir, I do not think so.

5298. We are very grateful to you, and I think that is all we need from you.—Thank you very much, Sir.

(The witnesses withdrew)



SCOTTISH MEDICAL PRACTICES COMMITTEE

Graph referred to in Q 5344

MEMORANDUM OF EVIDENCE BY THE SCOTTISH ASSOCIATION OF EXECUTIVE COUNCILS FOR THE ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

1. The Scottish Association of Executive Councils was formed at the inauguration of the National Health Service in 1948. The Association succeeded the Scottish Association of Insurance Committees formed in 1913 and, with the fortunate succession of a number of members of the former Association, has had the benefit of the considerable experience gained in the administration of the National Health Insurance Scheme. All Executive Councils in Scotland are in membership of the Association, which is recognised by the Secretary of State and consulted on all matters affecting the provision of services under Part IV of the National Health Service (Scotland) Act, 1947. Throughout the year, the work of the Association is undertaken by an Executive Committee elected annually at the Conference of representatives of the constituent Executive Councils.

2. In this memorandum the views of the Association are given on the points raised by the Secretary to the Royal Commission in his letter to the Association dated 8th April, 1958.

MEDICAL SERVICES

The Arrangements for entry of Doctors into General Practice

3. There are three means of entry into general practice, viz.:—

- (a) The setting up of a new practice.
- (b) Assumption as a partner into an existing practice, and
- (c) Succession in an advertised vacancy.

4. Before he has to decide which way he should seek to take, the doctor has already travelled far. Behind him lies at least six years of study and one pre-registration year, with probably also two years National Service. A considerable portion of his earning life has gone, much expenditure has already been incurred and still the way ahead may not be easy.

5. *Setting up a New Practice*: This way is the most difficult. With almost 100 per cent of the population already on doctors' lists, the new doctor must attract patients from his established colleagues. The more ethical his approach, the more difficult his task tends to be.

6. There are certain inescapable expenses and obligations, e.g. surgery accommodation must be provided, a car and telephone will be necessary and the doctor has to be on call twenty-four hours a day.

7. If the doctor enters a new housing area considerably removed from existing consulting accommodation, he may reasonably hope that mere convenience will draw some patients towards him and that thereafter diligence and ability may lead to a worthwhile practice. But he must first have convenient living and consulting accommodation. In this connection, he will usually have to deal with Local Authorities, who, if they have accommodation to rent, will, at least in respect of the consulting accommodation, be obliged to do so at an "economic rent" which may be quite substantial. If he builds accommodation, he will generally do so at considerable cost on borrowed money.

8. To make a reasonable living within a reasonable time in a new practice in an area not considerably affected by transfers of population is still more difficult. The fact that the average list in an area exceeds the general or national average is no guarantee of success. Indeed, there are indications that a new doctor frequently acquires his patients from the doctors with the smaller lists.

9. The Report of the Scottish Medical Practices Committee for the year ended 30th June, 1957 shows that in the period from 1953 to 1st April, 1957, 22 doctors were awarded Initial Practice Allowances. In ten cases, the districts of practice had been listed as under-doctored at the date of award. Six doctors had patients at the date of award and had practised in the area for a time or had been

appointed to a vacancy. Sixteen doctors remained in practice in the districts at 1st April, 1957. Six had resigned for the following reasons:—

1—to take up a Hospital post.

1—gave up practice to remain on the Medical List as assistant to another doctor.

1—resigned owing to ill-health.

2—resigned on being appointed to vacancies in other areas.

1—resigned on emigrating to New Zealand.

10. *Assumption as a Partner in an existing Practice*: This is now the most common means of entry into general practice. It frequently follows a preliminary period of assistantship in the practice in question. The assumption of a partner in an existing practice has the advantage of ensuring continuity and reduces the likelihood of patients dispersing during the period of a vacancy.

11. Arrangements for "loadings" and the calculation of payments to partnerships on the basis of "notional" lists help in the introduction of partners. It should, however, be noted that a large number of doctors entering partnership practice are not "additional" partners but fill vacancies caused by deaths or retirements.

12. The Association believe that some consideration should be given to measures to stimulate further the introduction of more "additional" partners. This might be done by arranging for the payment to pre-1948 practitioners assuming additional partners of part of their compensation for loss of right to sell goodwill.

13. At 31st March, 1958, 1,660 doctors practised in partnership in Scotland. Annexed, as Appendix 1, is a statement showing the proportions in which the partnership incomes were shared.

14. *Succession in an Advertised Vacancy*: At the beginning of the Service, it was generally believed that this would be the most usual means of entry into general practice.

15. With the growth of partnership practice and existing arrangements for the filling of partnership vacancies by consulting with the remaining partners, the number of advertised vacancies is small and apparently will be smaller in the years ahead.

16. Annexed, as Appendix 2, is a statement giving information as to the location and the size of vacancies advertised in Scotland during the three years to 31st March, 1958 and the number of applications received.

17. Annexed, as Appendix 3, is a statement which discloses that, while 2,403 applications were received in vacancies advertised during the three years to 31st March, 1958, the number of applicants concerned was 867.

18. Annexed, as Appendix 4, is a statement classifying these 867 applicants by completed years since graduation and post held at time of application.

19. Annexed, as Appendix 5, is a statement classifying successful applicants by the number of applications made in vacancies before appointment.

20. Annexed, as Appendix 6, is a statement classifying successful applicants by completed years since graduation and post held at time of application.

21. Annexed, as Appendix 7, is a statement classifying successful applicants by registered qualifications.

Arrangements for the Employment of Assistants by General Medical Practitioners

22. There is a place for the employment of assistants by senior practitioners at their professional peak. Indeed, the Association believe that a period of assistantship is a most desirable preliminary to entry into full general practice. Accordingly, satisfactory arrangements for the employment and training of assistants are an essential part of the Service.

23. The arrangements under which certain practitioners are recognised as "trainer" practitioners are approved in principle but there is probably a case for a detailed enquiry as to whether these arrangements are serving the purpose for which they were introduced. In order to prevent any abuse of the arrangements

for the training of assistants, the Association are of opinion that it might be desirable to provide that the recognition of a principal as a "trainer" practitioner should not be continued for a period of more than two years without a break unless where it appears that no other suitable "trainer" is available. (See also para. 45 as to joint training in hospital and general practice.)

24. Stricter control over the employment of assistants other than "trainees" should be introduced. The additional number of patients permitted to a doctor employing an assistant should be considerably limited so as to reduce the possibility of an assistant being employed solely for the purpose of permitting a large increase of the principal's list. On the other hand, the employment of assistants in approved cases should be facilitated and consideration might be given to the possibility of providing that the appointment of an assistant should not decrease the amount of the principal's income as calculated for superannuation purposes.

25. Annexed, as Appendix 8, is a statement in regard to the employment of assistant medical practitioners (other than "trainee" assistants) at 31st March, 1958. The assistants are classified by age and completed years of service as assistants. The years in which assistants were first employed in the practices concerned are shown. The salaries being paid at 31st March, 1958 are summarised. It would appear that there might be a case for considering whether grading of salaries would be appropriate in any review of the general arrangements for the employment of assistants.

Existing Arrangements for the Remuneration of Doctors and their relation to standards of Professional Work.

26. The Association are not directly concerned with rates of remuneration. These should be determined by appropriate negotiating machinery.

27. Remuneration should be sufficient to make the profession attractive to the ablest students.

28. There are obvious doubts as to the fairness of the present system of remuneration by capitation payments. It is a convenient method but difficult to defend as there is no direct relationship between remuneration paid and the standard of professional work.

29. The Association would not object to a different system if some means could be found of recognising special skill and experience. But, as there appears to be no yard-stick with which to measure the skill of a doctor in diagnosis and treatment, the Association cannot suggest a method.

30. The Association believe that there should be some financial incentive to improved services by the provision of special premises and the employment of nurses or ancillary staff. At present, the doctor with the largest list and the lowest expenses gains most.

31. Other points requiring special consideration in any review of financial arrangements include (a) the position of doctors in single practice areas where the standard of skill required is necessarily high but where there are no opportunities for increasing lists, and (b) the possibility of a scheme to supply emergency locums for doctors off duty through sickness and possibly the supply of locums for small list doctors in isolated areas during holiday periods.

The Desirable Size of List

32. The number of patients who can be adequately looked after by a practitioner must necessarily vary according to the practitioner's area of practice, his age and general fitness. The age groups of the patients within a particular practice are also of importance.

33. The maximum numbers at present permitted are considerably in excess of the average numbers and, in the opinion of the Association, are excessive.

34. Generally speaking, a doctor in an urban area should be able to give adequate treatment to a larger number of patients than a doctor in a sparsely populated area where patients find it more difficult to attend the doctor's surgery and travelling is time-consuming.

35. In the opinion of the Association, the desirable size of a list of a single-handed practitioner in an urban area is something in the region of 2,000/2,500 patients and in a rural area something in the region of 1,500/2,000 patients. The permitted increase in respect of the employment of an assistant should be in the region of 1,000 patients. The maximum permitted to any principal in a partnership in an urban area should not be more than 2,500 and in a rural area not more than 2,000.

36. In the opinion of the Association, the question of the relationship between the age of the practitioner and the size of his list also requires some consideration. So long as there is no compulsory age for retiral, it might be reasonable to provide that, on attaining the age of say 70, a practitioner's list should be limited in size, that he should not be permitted to employ an assistant and that his share in any partnership income should be reviewed.

The load of work falling on General Medical Practitioners

37. It seems clear that, since the beginning of the National Health Service, the load of work falling on general medical practitioners has considerably increased. This would appear to arise from greater demands by the public, from the needs of an ageing population and possibly also from the stress inherent in present day conditions.

38. It is thought that in rural areas the load of work is probably almost double since the advent of the National Health Service and that in urban areas, despite readier access to hospital facilities, the increased load of work is almost as great.

39. It appears to the Association that some of the work falling on practitioners might be done by qualified almoners or social workers and, generally, it would appear that a closer co-operation between the medical and social services might be desirable.

The Relationship between Medical Practice in Hospitals on the one hand and General Practice on the other

How far is weight given or ought to be given in considering applications for vacancies in general practice to experience of hospital work?

40. In considering applications for vacancies in general practice, Councils look for broad experience in general practice and hospital work. Applicants with experience in both branches of the Service are generally given preference over those with sectional experience only.

41. The Association are of opinion that a minimum of one year's hospital experience is desirable and that hospital midwifery experience is of particular importance.

42. When considering applications, care has to be taken to find out what kind of work the applicant has been doing in hospital. Prolonged hospital experience is probably not desirable. After one or two years as a house surgeon or house physician, hospital experience tends to become too specialised and less valuable than experience in general practice itself.

How far it is, or ought to be, possible for doctors to leave general practice and spend most or all of their time on hospital work

43. The value to general practice of contact with hospital work is so great that it should be possible for the general practitioner to do some work in hospital as well as his family doctoring.

44. There seems to be little enthusiasm for combining hospital and general practice appointments. There are difficulties but these should not be insuperable. One is that the doctor in general practice finds it difficult to be at a hospital at set hours, particularly if it is some distance away from his main practice area.

45. In the opinion of the Association, the establishment of general practitioner units in teaching hospitals would help to bring about the good liaison which it is desirable that practitioners should have with their hospital colleagues. Such units would also provide experience for students.

What arrangements might be made (assuming the possibility of part-time service in junior hospital grades) to enable young doctors to spend part of their time in general practice and part in hospital before they finally decide on which side their careers should lie?

46. To enable doctors to spend part of their time in general practice and part in hospital before they finally decide on which side their career should lie, the Association strongly commend the scheme for combined training in general practice and hospital work introduced in 1956 after consultations between the Joint Consultants Committee (Scotland) the General Medical Services Sub-Committee (Scotland) and the Department of Health for Scotland. Unfortunately, this combined training scheme does not seem to have received the support it deserves. Nevertheless, the statement of policy agreed between the interested Committees and the Department of Health would appear to be sound.

47. Annexed, as Appendix 9, is a copy of the Statement of Policy agreed between the Joint Consultants Committee (Scotland), the General Medical Services Sub-Committee (Scotland) and the Department of Health for Scotland.

DENTAL SERVICES

48. A dental practitioner is free to choose his own area of practice and it would appear that his decision will be made mainly on economic and partly on personal grounds.

49. At the present time, with a considerable shortage of dental practitioners, new practitioners would appear to tend to engage in general practice in centres of considerable population. In this decision, they are, no doubt, to some extent influenced by their desire to make arrangements for the education of their children.

50. In some of the more sparsely populated areas, the shortage of dentists is acute. The Association are of opinion that consideration should be given to the introduction of inducement grants where these are necessary for the provision of a satisfactory dental service for remote areas.

Arrangements for the employment of Assistants by General Dental Practitioners

51. Annexed, as Appendix 10, is a statement in regard to the employment of assistant dental practitioners at 31st March, 1958. The assistants are classified by age and completed years of service as assistants. The years in which assistants were first employed in the practices concerned are shown. The salaries being paid at 31st March, 1958 are summarised.

Existing Arrangements for the Remuneration of Dentists and their relation to Standards of Professional Work

52. As in the case of the medical services, the Association are not directly concerned with rates of remuneration. These should be determined by appropriate negotiating machinery.

53. Remuneration should be sufficient to ensure that the profession is attractive to the ablest students.

54. As in the case of medical services, there would appear to be some case for considering whether it might be possible to recognise special skill and experience. At the moment, the highest payments are made to those who do the greatest amount of work and there is no obvious relationship between the payments made and the standard of work.

55. In any profession, there is tendency under pressure for standards to fall. In the dental profession, the necessary safeguards would appear to be measures to increase the number of practitioners and to ensure that reasonable remuneration can be earned without excessive strain.

The Load of Work falling on Dental Practitioners

56. It would appear that the load of work falling on dental practitioners since the introduction of the National Health Service has vastly increased, and in recent years there has been a considerable increase in the amount of conservative treatment given. This form of treatment would appear to be most exacting and to call for a high degree of skill and concentration.

57. While the load of work falling on an individual practitioner is governed by the number of patients he chooses to accept and the extent of treatment necessary, the demands of the public have been such that the load of work on most practitioners has been heavy.

58. In the early years of his practice, the new dental practitioner has considerable capital outlay on modern equipment and to recover this his working hours are usually fairly long.

59. It would appear that the physical demands of dental practice are considerable and that the dentist's professional peak is reached at an earlier stage than in the medical profession. After the professional peak is passed, it generally appears that the dentist's earnings fall more steeply than those of the medical practitioner whose list of patients only slowly declines.

APPENDIX 1

DOCTORS PRACTISING IN PARTNERSHIP

At 31st March, 1958, doctors practised in partnership as follows:—

In partnerships of two	...	...	...	...	...	950
In partnerships of three	...	...	...	...	...	477
In partnerships of four	...	...	...	...	...	164
In partnerships of five	...	...	...	...	...	45
In partnerships of six	...	...	...	...	...	24

As at 31st March, 1958, the completed years of the partnerships and the shares of profits received by the individual partners were as follows:—

Shares received by Individual Partners	Completed Years of Partnership									Total
	1	2	3	4	5	6	7	8	9	
<i>Partnerships of Two</i>										
21-30 per cent. ...	6	4	—	1	6	—	—	—	4	21
31-40 per cent. ...	57	35	22	20	30	9	7	4	18	202
41-49 per cent. ...	7	1	5	3	14	5	5	3	8	51
50 per cent. ...	24	10	18	32	18	30	24	26	126	308
51-60 per cent. ...	14	10	12	10	28	9	7	4	15	109
61-70 per cent. ...	52	27	17	14	18	3	5	3	12	151
71-80 per cent. ...	3	4	—	—	4	—	—	—	3	14
										856
Members of Partnerships for which insufficient information as to sharing is available ...										94
										950

Shares received by Individual Partners	Completed Years of Partnership									Total
	1	2	3	4	5	6	7	8	9	
<i>Partnerships of Three</i>										
10-20 per cent. ...	19	8	9	4	5	1	2	1	—	49
21-32 per cent. ...	23	9	10	13	14	8	3	5	11	96
33½ and equal ...	12	9	9	—	9	12	12	—	27	90
33-40 per cent. ...	46	17	24	25	19	6	7	5	11	160
41-50 per cent. ...	14	13	7	6	6	2	3	3	3	57
51-60 per cent. ...	1	—	1	—	1	1	—	—	—	4
										456
Members of Partnerships for which insufficient information as to sharing is available ...										21
										477
<i>Partnerships of Four</i>										
10 per cent. or less	1	—	—	—	1	—	—	—	—	2
11-15 per cent. ...	7	—	2	2	2	—	1	—	—	14
16-20 per cent. ...	11	7	—	3	3	4	2	—	2	32
21-25 per cent. ...	3	—	4	2	7	—	1	—	—	17
25 per cent. and equal ...	—	—	—	4	—	—	4	—	—	8
26-30 per cent. ...	19	1	2	3	15	4	8	—	2	54
31-40 per cent. ...	15	5	3	4	4	1	—	—	—	32
Over 40 per cent.	—	—	—	1	—	—	—	—	—	1
										160
Members of Partnerships for which insufficient information as to sharing is available ...										4
										164
<i>Partnerships of Five</i>										
10 per cent. or less	—	—	1	—	—	—	—	—	—	1
11-15 per cent. ...	1	—	—	2	—	—	—	1	—	4
16-20 per cent. ...	4	3	1	—	2	—	—	1	—	11
20 per cent. and equal ...	—	—	5	—	—	—	—	—	—	5
21-25 per cent. ...	5	2	2	2	3	—	—	3	—	17
26-30 per cent. ...	—	—	1	—	1	—	—	—	—	2
										40
Members of Partnerships for which insufficient information as to sharing is available ...										5
										45
<i>Partnerships of Six</i>										
10 per cent. or less	1	—	—	—	—	—	—	—	—	1
11-15 per cent. ...	3	—	3	2	—	—	—	—	—	8
16-20 per cent. ...	—	—	9	2	—	—	—	—	—	11
21-25 per cent. ...	2	—	—	2	—	—	—	—	—	4
										24

APPENDIX 2

ADVERTISED MEDICAL VACANCIES IN THE 3 YEARS TO 31ST MARCH, 1958
LOCATION AND SIZE OF VACANCIES WITH NUMBER OF APPLICATIONS RECEIVED

Vacancy No.	Location	Number of Patients on List	Total Number of Applications	Notes
1	Aberdeen and Kincardine...	2,621	83	Practice divided between 2 applicants.
2		1,254	38	
3		2,159	63	
4		1,682	64	
5		1,266	68	
6		840	55	
7		2,351	59	
8	Angus	2,020	80	
9		1,480	73	
10	Argyll and Bute	622	16	
11		875	40	
12		560	26	
13		813	33	
14		1,020	41	
5	Ayr	650	11	
6		2,550	50	
7		2,400	34	
8		2,400	75	
	Banff, Moray and Nairn ...	606	46	New practice at new town—Cumbernauld.
	Dumfries	3,400	44	
	Dumbarton	963	13	
		—	24	
	Fife	526	4	
		1,758	12	
	Inverness	593	33	
		1,714	50	
	Lanark	642	15	
		1,507	34	
		1,549	35	
		1,868	39	
32	Lothians and Peebles ...	1,736	51	
33		733	14	
34	Orkney	199	10	
35		897	8	
36		476	4	
37		170	6	
38		810	8	
39		176	8	
40		894	10	
41	Perth and Kinross ...	1,532	78	
	Forward ...		1,471	

Vacancy No.	Location	Number of Patients on List	Total Number of Applications	Notes
		<i>Forward ...</i>	1,471	
42	} <i>Renfrew</i> {	880	16	
43		2,350	58	
44	} <i>Ross and Cromarty ...</i> {	787	17	
45		793	40	
46	<i>Stirling and Clackmannan</i>	2,360	46	
47	} <i>Sutherland</i> {	1,406	51	
48		860	26	
49	} <i>Zetland</i> {	1,500	30	
50		940		
51		1,590	20	
52	} <i>Dundee</i> {	1,240	24	
53		1,326	15	Practice divided between 5 applicants.
54		2,000	24	
55		1,625	13	
56		2,270	25	
57	} <i>Edinburgh</i> {	1,261	12	
58		1,031	12	
59		1,059	20	Practice divided between 5 applicants.
60		1,650	35	
61		1,461	30	
62		2,104	34	
63		2,814	67	
64	} <i>Glasgow</i> {	2,850	37	
65		670	8	
66		500	12	
67		900	14	
68		2,800	61	
69		2,400	31	
70		2,570	34	
71		2,160	52	
72		1,500	13	
73		1,980	21	
74		1,860	14	
75		2,000	20	
			2,403	

* Vacancy followed appointment made in immediately preceding vacancy and remaining applications in that vacancy were used.

APPENDIX 3

ADVERTISED MEDICAL VACANCIES IN THE 3 YEARS TO 31ST MARCH, 1958
 NUMBER OF APPLICANTS AND STATEMENT OF THE NUMBER OF VACANCIES
 FOR WHICH EACH APPLIED

After making allowance for applications lodged in respect of more than one vacancy, the number of applicants concerned in the submission of the foregoing 2,403 applications was								867
Applying in one vacancy only	...	...	...	...	...	...	...	433
two vacancies	...	...	...	...	...	...	...	160
three vacancies	...	...	...	...	...	...	...	74
four vacancies	...	...	...	...	...	...	...	51
five vacancies	...	...	...	...	...	...	...	45
six vacancies	...	...	...	...	...	...	...	32
seven vacancies	...	...	...	...	...	...	...	16
eight vacancies	...	...	...	...	...	...	...	9
nine vacancies	...	...	...	...	...	...	...	7
ten vacancies	...	...	...	...	...	...	...	7
eleven vacancies	...	...	...	...	...	...	...	6
twelve vacancies	...	...	...	...	...	...	...	4
thirteen vacancies	...	...	...	...	...	...	...	5
fourteen vacancies	...	...	...	...	...	...	...	2
fifteen vacancies	...	...	...	...	...	...	...	6
sixteen vacancies	...	...	...	...	...	...	...	3
seventeen vacancies	...	...	...	...	...	...	...	2
eighteen vacancies	...	...	...	...	...	...	...	2
twenty-two vacancies	...	...	...	...	...	...	...	1
twenty-five vacancies	...	...	...	...	...	...	...	1
twenty-eight vacancies	...	...	...	...	...	...	...	1

867

APPENDIX 4

ADVERTISED MEDICAL VACANCIES IN THE 3 YEARS TO 31ST MARCH, 1958
 APPLICANTS CLASSIFIED BY COMPLETED YEARS SINCE GRADUATION AND
 POST HELD AT TIME OF APPLICATION

(Where more than one application was made, the post held at the time of the last application is quoted and years completed at that time are used. "Unemployed" means not employed within the 3 months preceding the application.)

Number of Applicants	Completed Years since Graduation	Post held at time of Application								
		Principal	Assistant	Trainee Assistant	Locum in General Practice	Hospital Officer	Unemployed	Forces	Local Authority Assistant Medical Officers	Others
1	47	—	—	—	—	—	1	—	—	—
1	44	—	—	—	—	—	1	—	—	—
1	43	1	—	—	—	—	—	—	—	—
1	40	1	—	—	—	—	—	—	—	—
1	39	1	—	—	—	—	—	—	—	—
1	37	1	—	—	—	—	—	—	—	—
1	35	1	—	—	—	—	—	—	—	—
4	34	3	—	—	—	—	—	—	—	1
4	33	3	—	—	1	—	—	—	—	—
6	32	5	—	—	—	—	1	—	—	—
4	31	3	—	—	—	—	—	—	—	1
8	30	6	—	—	2	—	—	—	—	—
5	29	3	1	—	1	—	—	—	—	—
5	28	3	—	—	—	—	1	—	1	—
3	27	3	—	—	—	—	—	—	—	—
4	26	2	1	—	—	—	—	1	—	—
2	25	1	—	—	—	—	—	—	—	1
5	24	2	—	—	1	—	—	1	—	1
11	23	6	—	—	2	1	—	—	1	1
6	22	2	1	—	—	—	1	—	—	2
4	21	2	—	—	—	1	—	—	1	—
10	20	6	2	—	1	—	—	—	—	1
14	19	10	2	—	—	2	—	—	—	—
15	18	14	—	—	—	1	—	—	—	—
20	17	14	1	—	3	1	1	—	—	—
12	16	8	1	—	1	—	1	—	—	1
21	15	15	—	1	1	3	1	—	—	—
22	14	15	2	1	2	—	—	—	2	—
19	13	11	3	—	4	—	—	—	1	—
26	12	20	2	—	4	—	—	—	—	—
27	11	15	9	—	1	—	1	—	—	1
31	10	18	5	—	4	2	1	—	—	1
40	9	25	11	—	2	2	—	—	—	—
65	8	22	25	1	6	7	1	1	2	—
87	7	25	44	2	9	5	—	1	1	—
107	6	23	52	6	8	11	2	2	1	2
95	5	25	40	9	10	8	2	—	—	1
79	4	11	35	8	8	12	—	1	2	2
55	3	4	18	17	3	7	3	3	—	—
36	2	1	14	12	4	5	—	—	—	—
8	1	—	1	2	—	5	—	—	—	—
867		331	270	59	78	73	18	10	12	16

APPENDIX 5

ADVERTISED MEDICAL VACANCIES IN THE 3 YEARS TO 31ST MARCH, 1958
SUCCESSFUL APPLICANTS

As already noted, certain of the 75 practices advertised were divided. The total number of successful applicants was ... 84

Successful Applicants classified by number of applications made in vacancies before appointment

Applying in one vacancy only	...	...	...	...	...	...	28
two vacancies	...	...	...	...	...	...	12
three vacancies	...	...	...	...	...	...	14
four vacancies	...	...	...	...	...	...	7
five vacancies	...	...	...	...	...	...	5
six vacancies	...	...	...	...	...	...	5
seven vacancies	...	...	...	...	...	...	1
eight vacancies	...	...	...	...	...	...	1
nine vacancies	...	...	...	...	...	...	2
eleven vacancies	...	...	...	...	...	...	2
twelve vacancies	...	...	...	...	...	...	3
thirteen vacancies	...	...	...	...	...	...	2
sixteen vacancies	...	...	...	...	...	...	1
seventeen vacancies	...	...	...	...	...	...	1
							84

NOTE: Within the 3 years to 31st March, 1958, three of the foregoing applicants were each successful in two vacancies.

APPENDIX 6

SUCCESSFUL APPLICANTS CLASSIFIED BY COMPLETED YEARS SINCE GRADUATION AND POST HELD AT TIME OF APPLICATION

Number of Successful Applicants	Completed Years since Graduation	Post held at time of Application								
		Principal	Assistant	Trainee Assistant	Locum in General Practice	Hospital Officer	Unemployed	Forces	Local Authority Assistant Medical Officers	Others
1	39	1	—	—	—	—	—	—	—	—
1	33	1	—	—	—	—	—	—	—	—
2	30	2	—	—	—	—	—	—	—	—
1	29	1	—	—	—	—	—	—	—	—
2	28	—	—	—	—	—	1	—	1	—
1	23	1	—	—	—	—	—	—	—	—
1	21	—	1	—	—	—	—	—	—	—
1	20	1	—	—	—	—	—	—	—	—
1	19	1	—	—	—	—	—	—	—	—
3	18	3	—	—	—	—	—	—	—	—
2	17	1	—	—	—	1	—	—	—	—
1	16	—	—	—	—	—	—	—	—	—
2	14	1	—	—	—	—	—	—	1	—
4	13	2	—	—	2	—	—	—	—	—
4	12	3	1	—	—	—	—	—	—	—
5	11	3	2	—	—	—	—	—	—	—
2	10	1	1	—	—	—	—	—	—	—
5	9	4	—	—	1	—	—	—	—	—
9	8	4	4	—	1	—	—	—	—	—
8	7	4	1	1	—	1	1	—	—	—
14	6	6	6	—	1	—	1	—	—	—
6	5	2	4	—	—	—	—	—	—	—
3	4	1	—	—	1	1	—	—	—	—
3	3	—	1	1	—	—	—	—	—	1
2	2	—	1	—	1	—	—	—	—	—
84		43	22	2	8	3	3	—	2	1

APPENDIX 7

SUCCESSFUL APPLICANTS CLASSIFIED BY REGISTERED QUALIFICATIONS

<i>Registered Qualifications</i>	<i>Number of successful Applicants</i>
M.B., Ch.B.	55
M.B., Ch.B., D.Obst.R.C.O.G.	11
M.B., Ch.B., M.A.	2
M.B., Ch.B., M.D.	1
M.B., Ch.B., F.R.F.P.S.	1
M.B., Ch.B., B.Sc., D.T.M. & H.	1
M.B., Ch.B., B.Sc.	1
M.B., Ch.B., D.C.H.	1
L.R.C.P., L.R.C.S., L.R.F.P.S.	9
M.R.C.S., L.R.C.P., M.A.	1
L.M.S.S.A.	1
	<u>84</u>

APPENDIX 8

EMPLOYMENT OF ASSISTANT MEDICAL PRACTITIONERS
(OTHER THAN "TRAINEE" ASSISTANTS)

At 31st March, 1958, assistants employed totalled:—

Full Time	...	...	...	...	221
Part Time	...	...	...	...	25
					<u>246</u>

ASSISTANTS CLASSIFIED BY AGE

<i>Full Time</i>		<i>Part Time</i>	
<i>Age</i>	<i>Number of Assistants</i>	<i>Age</i>	<i>Number of Assistants</i>
25	2	26	1
26	5	30	1
27	17	31	1
28	21	32	1
29	29	33	3
30	26	34	1
31	32	35	1
32	25	36	1
33	14	39	2
34	9	40	2
35	8	41	3
36	4	44	1
37	8	45	1
38	4	50	1
39	3	52	1
40	1	53	1
43	1	60	1
47	2	64	1
52	1	65	1
53	1		<u>25</u>
54	2		
56	2		
57	1		
58	1		
59	2		
	<u>221</u>		

COMPLETED YEARS OF SERVICE AS ASSISTANTS

<i>Full Time</i>				<i>Part Time</i>			
<i>Years Completed at 31st March, 1958</i>				<i>Years Completed at 31st March, 1958</i>			
<i>Number of Assistants</i>				<i>Number of Assistants</i>			
Less than 1	...	...	101	Less than 1	...	...	9
1	...	...	54	1	...	...	1
2	...	...	22	2	...	...	2
3	...	...	16	3	...	...	1
4	...	...	6	4	...	...	—
5	...	...	5	5	...	...	2
6	...	...	2	6	...	...	2
7	...	...	4	7	...	...	4
8	...	...	1	8	...	...	—
9	...	...	10	9	...	...	4
			<u>221</u>				<u>25</u>

YEARS IN WHICH ASSISTANTS WERE FIRST EMPLOYED IN THE PRACTICES CONCERNED

<i>Full Time</i>				<i>Part Time</i>			
<i>Assistant First Employed</i>				<i>Assistant First Employed</i>			
<i>Number of Practices</i>				<i>Number of Practices</i>			
1948	...	...	46	1948	...	...	4
1949	...	...	16	1949	...	...	1
1950	...	...	22	1950	...	...	4
1951	...	...	10	1951	...	...	2
1952	...	...	14	1952	...	...	1
1953	...	...	11	1953	...	...	2
1954	...	...	17	1954	...	...	1
1955	...	...	18	1955	...	...	2
1956	...	...	21	1956	...	...	2
1957	...	...	33	1957	...	...	3
1958	...	...	13	1958	...	...	3
			<u>221</u>				<u>25</u>

SUMMARY OF SALARIES BEING PAID AT 31ST MARCH, 1958

Full Time

<i>Salary Range £</i>	<i>Number of Assistants in Range</i>	<i>Notes</i>
To 400 ...	1	Wife of principal.
400—500 ...	2	Includes wife of a principal.
501—600 ...	1	Wife of principal.
601—700 ...	6	Includes wife of a principal.
701—750 ...	14	
751—800 ...	15	
801—850 ...	38	
851—900 ...	33	
901—950 ...	15	
951—1,000 ...	48	
1,001—1,050 ...	14	Includes daughter of a principal.
1,051—1,100 ...	13	
1,101—1,150 ...	8	
1,151—1,200 ...	8	
1,201—1,250 ...	1	
1,251—1,300 ...	2	
1,301—1,350 ...	—	
1,351—1,400 ...	1	
.....		
1,551—1,600 ...	1	
	<u>221</u>	

Part Time

<i>Salary Range £</i>	<i>Number of Assistants in Range</i>	<i>Notes</i>
Nil ...	1	Wife of principal.
to £100 ...	—	
101—150 ...	3	
151—200 ...	3	
201—250 ...	—	
251—300 ...	1	
301—350 ...	3	
351—400 ...	3	Includes mother of a principal.
401—450 ...	1	
451—500 ...	2	
501—550 ...	—	
551—600 ...	—	
601—650 ...	2	
651—700 ...	1	
701—750 ...	—	
751—800 ...	2	
801—850 ...	1	
851—900 ...	1	
1,800 ...	1	
	<u>25</u>	

APPENDIX 9

GENERAL PRACTITIONERS AND THE HOSPITAL SERVICE

Statement of Policy agreed between the Joint Consultants Committee (Scotland), the General Medical Services Sub-Committee (Scotland), and the Department of Health for Scotland

1. This statement of policy has been drawn up in consultation between the Joint Consultants Committee (Scotland), the General Medical Services Sub-Committee, and the Department of Health for Scotland, and is now commended for joint implementation by Regional Consultants and Specialists Committees, hospital medical staffs, and Hospital Boards on the one hand, and by Local Medical Committees and Executive Councils on the other.

2. It is agreed that, as recommended in the Scottish Health Services Council's report on "The General Practitioner and the Hospital Service", steps should be taken to foster the concurrent employment of doctors in general practice on the one hand and in hospital practice on the other. It is accordingly agreed that—

- (i) a combined training scheme should be developed which offers the practitioner concurrent training and experience in both fields, on completion of his pre-registration hospital year or on completion of National Service if later; and
- (ii) entry into general practice on a part-time basis should be made easier for doctors who have continued in hospital service up to the level of registrar, but who have decided not to devote the whole of their subsequent career to hospital and specialist work.

3. *Combined Training.* The basis of this scheme is that a practitioner accepted for training will undertake a two-year programme of work under which he will spend approximately half his time in hospital employment, at the senior house officer or registrar level according to the needs of the particular hospital, and the other half as a trainee assistant in general practice under the guidance and tuition of an experienced practitioner approved for the purpose by the Regional Selection Committee.

4. As nearly as possible the trainee will carry on both elements of his training concurrently, spending half of each day in hospital and the other half outside. But modifications to suit local conditions will be permissible—for example, alternate months, or even alternate periods of up to one year might be devoted whole-time to hospital service and to general practice. Since the trainee has to play an effective part as a member of the hospital staff, the latter type of arrangement will be practicable only where two trainees are simultaneously employed, exchanging between general practice and hospital so that there is always one of the two in each field.

5. There will be a tripartite contract between the hospital, the training practitioner, and the trainee, covering the whole period of two years. If the hospital post is at senior house officer level, the trainee will receive £745 for the first year and £775 for the second; if the hospital post is at registrar level, the first year's rate will be £775 and the second £850. The training practitioner will be entitled to the usual £150 training fee and £150 (maximum) for additional car expenses, in each case spread over the two-year period. As a matter of convenience, payments to the trainee will be channelled through the hospital, the Executive Council contributing £775 over the period; and the additional car allowances can also be paid in this way if the expenditure is to be incurred by the trainee and not by the training practitioner.

6. *Part-time Practice.* To cater for the practitioner who has completed his appointment as a registrar, openings should also be sought for part-time employment in general practice as a partner (probably after a preliminary period as assistant with a view) combined with part-time employment in hospital in any of the recognised hospital grades (including the "general practitioner" grade under

paragraph 10 (b) of the Terms and Conditions of Service). In such cases the remuneration for general practice would be a matter entirely for the practice in which the practitioner participated, and no question of a consolidated payment covering both forms of employment would arise.

7. Implementation of Policy. The policy embodied in this statement can be implemented only by action on the part of those familiar with local conditions in detail. This means that hospital medical staff themselves, acting through Medical Staff Committees where these exist, and after preliminary consultation with the appropriate Local Medical Committee if desired, should make it their business to consider what particular hospital posts might suitably be filled by trainees under paragraphs 3 to 5, and by part-time practitioners under paragraph 6. It may be appropriate to envisage the employment of two part-time officers in one whole-time post. The Local Medical Committee should then be invited to examine in detail with the hospital staff whether such openings in the hospital service could be linked with complementary opportunities in general practice of the appropriate kind.

8. Where complementary openings in hospital service and general practice are identified in this way, appropriate recommendations should be made by the hospital staff to the Hospital Board concerned, and by the Local Medical Committee to the Executive Council. When the Board and the Council have accepted the recommendations, it will be for the Board to arrange advertisement of the vacancy, and to associate the practitioner or practitioners concerned (as trainer or potential partner) in the selection of the successful applicant.

9. Hospital authorities are being asked to provide the secretarial services necessary for these studies and consultations, and also any other assistance in their power; in particular, Medical Superintendents will have an important part to play. The Department's Regional Medical Officers will also be available for advice and assistance. While it is not expected that any great number of hospital posts will under present circumstances be found suitable for combination with general practice, the view of the bodies subscribing to this Statement of Policy is that even a few openings of this kind would be of real value both to the hospital service and to general practice.

Department of Health for Scotland,
St. Andrew's House,
Edinburgh, 1.

March, 1956.

APPENDIX 10

EMPLOYMENT OF ASSISTANT DENTAL PRACTITIONERS

At 31st March, 1958, assistants employed totalled:—

Full Time	...	...	...	...	128
Part Time	...	...	...	...	6
					<u>134</u>

ASSISTANTS CLASSIFIED BY AGE

*Full Time**Part Time**Age**Number of
Assistants**Age**Number of
Assistants*

23	...	...	...	3	29	...	...	...	2
24	...	...	...	2	30	...	...	...	1
25	...	...	...	7	33	...	...	...	1
26	...	...	...	13	44	...	...	...	1
27	...	...	...	11	77	...	...	...	1
28	...	...	...	12					<u>6</u>
29	...	...	...	13					<u>—</u>
30	...	...	...	13					
31	...	...	...	11					
32	...	...	...	8					
33	...	...	...	4					
34	...	...	...	2					
35	...	...	...	5					
36	...	...	...	1					
38	...	...	...	2					
39	...	...	...	1					
40	...	...	...	1					
41	...	...	...	3					
42	...	...	...	5					
43	...	...	...	1					
46	...	...	...	1					
48	...	...	...	1					
50	...	...	...	1					
57	...	...	...	1					
58	...	...	...	1					
60	...	...	...	1					
62	...	...	...	1					
63	...	...	...	2					
66	...	...	...	1					
				<u>128</u>					

COMPLETED YEARS OF SERVICE AS ASSISTANTS

*Full Time**Part Time*

<i>Years Completed at 31st March, 1958</i>				<i>Number of Assistants</i>	<i>Years Completed at 31st March, 1958</i>				<i>Number of Assistants</i>
Less than 1	...	...	...	42	Less than 1	...	...	...	1
1	...	...	...	26	1	...	...	...	2
2	...	...	...	21	3	...	...	...	1
3	...	...	...	12	8	...	...	...	1
4	...	...	...	4	9	...	...	...	1
5	...	...	...	2					—
6	...	...	...	2					6
7	...	...	...	4					—
8	...	...	...	6					
9	...	...	...	9					
				<hr/> 128 <hr/>					

YEARS IN WHICH ASSISTANTS WERE FIRST EMPLOYED IN THE PRACTICES CONCERNED

*Full Time**Part Time*

<i>Assistant First Employed</i>				<i>Number of Practices</i>	<i>Assistant First Employed</i>				<i>Number of Practices</i>
1948	...	...	...	36	1948	...	...	...	3
1949	...	...	...	10	1949	...	...	...	1
1950	...	...	...	13	1951	...	...	...	1
1951	...	...	...	9	1957	...	...	...	1
1952	...	...	...	6					—
1953	...	...	...	6					6
1954	...	...	...	9					—
1955	...	...	...	11					
1956	...	...	...	10					
1957	...	...	...	15					
1958	...	...	...	3					
				<hr/> 128 <hr/>					

SUMMARY OF SALARIES BEING PAID AT 31ST MARCH, 1958

<i>Full Time</i>						<i>Notes</i>
<i>Salary Range</i>						
<i>Number of Assistants in Range</i>						
To £400	...	...	...	...	1	Wife of principal.
£						
401- 500	...	...	...	...	—
501- 600	...	...	...	...	2	
601- 700	...	...	...	...	1	Wife of principal.
701- 800	...	...	...	...	1	
801- 900	...	...	...	...	7	
901-1,000	...	...	...	...	5	
1,001-1,100	...	...	...	...	18	Includes wife of a principal.
1,101-1,200	...	...	...	...	17	One also receives bonus.
1,201-1,300	...	...	...	...	28	Two also receive bonuses.
1,301-1,400	...	...	...	...	5	
1,401-1,500	...	...	...	...	13	One also receives bonus.
1,501-1,600	...	...	...	...	12	One also receives bonus.
1,601-1,700	...	...	...	...	2	
1,701-1,800	...	...	...	...	4	
1,801-1,900	...	...	...	...	5	
1,901-2,000	...	...	...	...	5	
2,001-2,100	...	...	...	...	1	
...						
2,401-2,500	...	...	...	...	1	
					128	

<i>Part Time</i>						
To £400	...	...	...	...	2	One is father of principal.
£						
401- 500	...	...	...	...	—
501- 600	...	...	...	...	1	
601- 700	...	...	...	...	2	
...						
901-1,000	...	...	...	...	1	
					<hr/> 6	

Examination of Witnesses

DR. J. M. GILL, *President*

COL. R. S. WEIR, *Vice-President*

MR. T. HUNTER

MR. A. R. HOWIE, *Secretary*

on behalf of the Scottish Association of Executive Councils

Called and Examined

5299. *Chairman*: Dr. Gill, would you like to act as the principal spokesman, or are you all taking part?—*Dr. Gill*: We are all taking part.

5300. But, on the whole, we regard you as the leader of this delegation.—*Yes*.

5301. We have now covered a very great deal of ground on the general medical and dental services, so we shall not be questioning you very closely on some of the points of interest in your memorandum; also some of the other points are a bit outside our terms of reference.

Sir Hugh Watson will be doing most of the questioning, because he has acted as the Chairman of the Sub-Committee which prepared the questions arising out of the evidence, but I would like to start by thanking you very much, not only for coming here today but also for the great amount of factual information which you have given us, as well as your views on the questions we asked you. Your memorandum is extremely useful to us and must have taken a great deal of trouble. The figures in the Appendices, for instance, tell us a great deal, and in some cases the information is of a kind which we have not previously had.—That is due, of course, to the work of our Secretary, Mr. Howie.

5302. *Sir Hugh Watson*: Dr. Gill, you start off your memorandum very appropriately by talking about the question of entry into general practice.—*Yes*.

5303. In the view of your Association, has the scheme for giving initial practice allowances been successful?—*Yes*, our Association think that the Initial Practice Allowance is a successful scheme.

5304. You think the allowances are adequate in point of amount?—*We did think that, perhaps, the allowances could be a little more generous, and perhaps last for longer than three years.*

5305. That was the next point I was coming to. You think that possibly

there could be cases where three years may be too short?—*Yes, we did think that.*

5306. It was put to us by the Scottish Medical Practices Committee, whom we have just seen, that they might be allowed a longer period to taper off.—*Yes. We have not considered it as far as that, but we did think it might last a little longer.*

5307. Would you like to see more doctors setting up in practice on their own?—*Our information is largely based on the report of the Scottish Medical Practices Committee. We do think that in most areas it is very difficult for a doctor to set up in practice. We feel that, with the present method whereby the Scottish Medical Practices Committee decide on over- and under-doctored areas, the spread of practitioners in Scotland is fairly adequate, and we do not really think that doctors have very much chance of setting up in practice and making a success of it.*

5308. From information which we had from the Scottish Medical Practices Committee, we gather that the average number entering the profession in that way is about 10 in each year in Scotland.—*Yes.*

5309. Would you expect that number to be much improved on?—*We had not considered that, and I really do not know. I think that would be a fairly good average.*

5310. *Chairman*: What do you have up in your own district, which is in the North, is it not?—*Do you mean how many doctors started up there?*

5311. *Yes. Do you find difficulties there?—Practically no doctors start up in practice in the North-East area.*

5312. And is that partly because you do not have these new towns and rapidly growing suburbs?—*Yes, I think that would have a good deal to do with it, and also up in the North-East I think*

the average lists are rather lower than in some other parts of Scotland.

5313. *Sir Hugh Watson*: There was one phrase which rather intrigued the Commission in paragraph 5 of your memorandum, where you are talking about the difficulties of doctors establishing themselves of new. You say: "The more ethical his approach, the more difficult his task tends to be". What exactly does that mean, or would you rather leave it at that?—*Mr. Howie*: Having heard Dr. Baldwin this morning, I think he gave the same general indication that, if a doctor puts up his plate hoping to build a new practice, he simply has to sit and wait there for the patients to come. I do not know that there is much more that the Association would wish to say, other than that "the more ethical his approach, the more difficult his task tends to be".

5314. On the question of partnerships, we know that there are certain financial advantages as the result of the loadings to doctors who practise in partnerships. Would your Association think it desirable to adopt any further methods for stimulating partnerships?—*Dr. Gill*: The only other suggestion that we do make is contained in paragraph 12, in which we suggest that the pre-1948 practitioners might receive part of the compensation for the loss of goodwill on the assumption of a partner.

5315. That was the only suggestion which occurred to you?—That was the only other suggestion that we had.

5316. *Mr. Gunlake*: That suggestion has, in fact, been made officially and turned down?—I think so.

5317. *Chairman*: You have, I suppose, in Scotland a good many practices which by virtue of geography would be difficult to run as partnerships?—Yes, especially in the Highlands and some of the more isolated parts of Scotland, there could not be more than a single practitioner.

5318. And if, from a central pool, there were more financial inducements to form partnerships, these would inevitably, to some extent, be at the expense of the single-handed?—Yes, they would be, Sir.

5319. I wondered whether you had taken that into account in talking of more measures to stimulate partnerships.—The only measure that we recom-

mended was distinct from the central pool.

5320. Does this mean that you think the move towards partnerships has not been going quite fast enough?—No, we think the move towards partnerships has gone very far, and I think the figures show that. But we did feel that partnership is a very good method of doctors helping one another to give a better service to the public, and therefore we felt we should try to stimulate it as much as possible.—(*Mr. Howie*): It was put to the Association that, when a man assumes a partner, there is necessarily a reduction in his income. In pre-Health Service days, that reduction for a number of years was compensated by the capital which was put in. At the present time, if there is to be an assumption of a partner, this loss over the first year or two might be compensated by early payment of some part of the compensation.

5321. *Sir Hugh Watson*: Dr. Gill, on the question of filling partnership vacancies, the Commission know that it is common practice that, if a firm decide to assume a new partner, they select the man themselves, and then they apply for permission to take him on as a partner.—(*Dr. Gill*): Yes, that would be correct.

5322. That means that that particular vacancy is not advertised?—No. In the case of partnerships, I think that vacancies are never advertised by Executive Councils.

5323. That is a thing which apparently was not contemplated when the National Health Service started, is that right?—(*Mr. Howie*): I think the point the Association makes is that they had not contemplated that there would be so many partnerships. In the beginning it was thought that most of the vacancies would be single-handed vacancies, which would be advertised.

5324. What you are saying, really, is that this development of partnerships has rather altered the whole outlook of the thing?—Yes.

5325. Have you any views about that, Dr. Gill? Do you think that is a good thing?—(*Dr. Gill*): I think it is a very good thing, Sir. I think we are agreed that partnership practice is a good thing, and it is going to be very difficult to practise amicably with someone who has been thrust upon you. It is very

much better that the remaining partner should choose who he or she is going to work with.

5326. Mr. Gunlake and I, who are both in partnership in other kinds of businesses, would think it was essential and that you must have freedom of choice in that way. You find that that system is working well?—Yes, we do, Sir.

5327. On the question of partnerships, the Scottish Medical Practices Committee explained to us this morning that they have a limited oversight of partnership agreements.—Yes.

5328. Were you in the room when it was explained to us by Mr. Millar why the Committee is charged with the duty of overseeing these agreements?—Yes. [See Q. 5274.]

5329. Would you think that that could usefully be made compulsory in all partnerships?—There was some difference of opinion about that, but perhaps Mr. Hunter could speak about that.—(Mr. Hunter): Certain members of our Executive Committee thought it would be a good thing to have all partnership agreements examined by the Medical Practices Committee; others of us are rather of the opinion that it should be left to the parties themselves to make agreements. You must assume that the agreement would be a fair agreement. We cannot assume that the man is going to assume a partner on unfavourable terms, or in contravention of the Act, and some of us are of the opinion that there should not be compulsory examination of partnership agreements.

5330. Of course, as you know, what the Act is looking for is sale of goodwill.—Yes.

5331. What the Act makes illegal is the sale of goodwill, and the object of having these partnership agreements scrutinised by the Committee is to make sure that there is not in them any element of sale of goodwill.—Yes, I know. They also come before the Executive Councils in connection with notional payments, to see that there is at least one-third being paid to the lowest paid partner. But some of us do not like the idea of assuming that there are going to be illegal agreements. We are assuming that doctors are going to make agreements which are within the law.

5332. Would you think there was any case for having these agreements scrutinised by the Committee, from the point of view of protecting the interests of young partners?—That would appear to be the only advantage.

5333. On the question of assistants, in your paragraph 24 you suggested that there should be stricter control over the employment of assistants other than trainees, and in the next sentence you suggest a limitation on the number of additional patients to be permitted to a doctor employing an assistant. Would you suggest any other change?—Dr. Gill: There are already facilities, of course, for the Executive Council to scrutinise every two years the lists of principals employing assistants. No, I think these are all the suggestions we have—the scrutinising of the lists once every two years by the Executive Council, and limiting the extra number allowed by the employment of an assistant. By that means, we think that is all that would be required to be done.

5334. Would you agree with Dr. Baldwin of the Scottish Medical Practices Committee who told us that there do not come under his notice any substantial number of cases of doctors who have had assistants over a long period of years?—I know of none, Sir, in our area.—Mr. Howie: We had no particular information. In Appendix 5 we did indicate the number of practices having assistants. 46 practices have had assistants since 1948 but we do not know how long any individual assistant has been there.

5335. And would you suppose that, in point of fact, these 46 practices have had assistants all that time?—There may have been a break, Sir, but probably some have had them all the time.—Dr. Gill: We felt also that there may be practices of such a size that they can afford an assistant, and yet would not be sufficient to pay two principals. Also, the practices may be in an area where it is impossible for them to become any bigger, and in that case the only way the doctor can get help is to go on having a succession of assistants.

5336. But within your own area, you have not come across a case of this sort?—I do not know of any.

5337. We have had suggestions from other quarters—I think it is fair to say that this has been mostly in England—

that there has been an abuse of the system of employing assistants, and that certain doctors go on employing assistants year after year, without taking in partners. But you do not know about any cases of that sort in your area?—I do not know any. But I can visualise cases where it would be relatively uneconomic for a practitioner to take in a partner.—*Mr. Howie*: On page 1195, in Appendix 8, there is an indication of the period of service of the currently employed assistants. You will see that there is a total of 221 assistants, 101 of whom have been employed for less than one year.

5338. Would that be in the same practice?—Yes, I should imagine so. But at the other end of the table there are 10 who have been employed as assistants for 9 years. There may well be special circumstances in those cases.

5339. *Chairman*: Probably that number of 10 is composed of people who are prepared to go on being assistants?—They might be people who object to becoming principals.—*Mr. Hunter*: That number might include a wife, for example.

5340. You were saying, Dr. Gill, that you did not know of any cases where a practice had regularly employed assistant after assistant for a long number of years. But on page 1195, in Appendix 8, you have 46 practices which first employed an assistant in 1948, 16 in 1949, 22 in 1950 and so on. I wonder whether it would be possible for those top three figures to be dissected to see whether any of them had employed an assistant continuously, or changed assistants continuously since 1948, 1949 and 1950.—*Mr. Howie*: The return I asked for from the constituent Councils only asked for the present position, and a statement about when an assistant was first employed. There may well have been a break in these cases, but on the other hand it does not follow that there are not some who have been continuous. There may well have been some who were continuous.

5341. With that total of 84 practices, I should think it would be fairly easy to find out that information.—Yes, I think we could get that.

Chairman: I think it would be quite useful.

5342. *Sir Hugh Watson*: On the question of the remuneration of assistants, you have produced a table on page 1196,

in Appendix 8, which shows the remuneration paid to some 221 assistants. One notices that 149 of these are included in the bracket between £750 and £1,000 a year.—Yes.

5343. Have you any reason to believe that there is anything unfair about the present remuneration of assistants to medical practitioners?—*Dr. Gill*: I do not think we have, Sir.

5344. In other words, you think that a market level exists, and a doctor, if he wants an assistant, must pay the market price for him?—Yes, I should think so, Sir, and one must remember that some assistantships are very much more desirable than others. Smaller practices may have more congenial surroundings than the larger industrial practices, and although they are smaller they are still able to get assistants to go to these places. So that the assistants, themselves, in a way set the lowest figures.

5345. The Commission has had a good deal of evidence that it is difficult for young doctors to get themselves placed in employment, either as assistants or as principals, but particularly as principals.—Would we get any assistance from Appendix 4, which shows the advertised medical vacancies in the three years to 31st March, 1958? In that you will see that of the assistants who applied for the vacancies in these three years, those with 7 completed years or less since graduation formed only 23 per cent. of the total applicants.

5346. That is an instructive figure.—And, if one takes into account the fact that after a doctor graduates he has a year in hospital and two years in military service, that means to say that all these assistant practitioners with 7 years since their graduation, have only had 4 years in general practice.

5347. So on the whole matter you think that assistants are reasonably well paid?—Yes, I think they are, Sir.

5348. *Chairman*: You know, Dr. Gill, that we have sent a questionnaire to all assistants, so far as we can trace them at the appropriate date, in respect of their actual remuneration. But the median and average figure in your Appendix 8 is lower than we had understood was being paid when the B.M.A. gave us evidence about average remuneration.—These are the figures we got from our constituent Councils,

5349. *Sir Hugh Watson*: I think it is fair to say that the only thing the B.M.A. were able to give us was some review of the figures which had been offered in advertisements. The B.M.A. themselves had nothing to do with this matter at all.—*Mr. Howie*: Our statement is of superannuable remuneration. The only thing which might be excluded would be a car allowance.

5350. *Chairman*: In paragraph 23 you suggest that it might be desirable to provide that the recognition of a principal as a trainer practitioner should not be continued for a period of more than two years without a break, if there is anybody else available. Perhaps you heard Dr. Baldwin of the Scottish Medical Practices Committee say that normally they insisted on a break after four years, because they thought that the man needed a rest from training. I wondered what was the particular object of this statement of yours.—*Dr. Gill*: What we felt, Sir, was that if a practitioner has a trainee assistant, he gears up his work to running his practice with assistance, and it may be that if he goes on for longer than two years and there is then a break, he finds it very difficult to adjust himself to working single-handed again. I think that is the main reason for this statement of ours.

5351. Have you had many complaints from practitioners who have been trainers for four years, saying that they wished they had been made to break after two years?—No, we have not had that, Sir.

5352. If it is solely their interest which you are considering, they would be the ones to make representations?—Yes, that is so.—*Mr. Howie*: I think it was in the mind of the Association when the paragraph was constructed that, without any factual information, one has heard considerable criticism of the actual working of the scheme. And if any steps are to be taken to prevent any abuse, which may or may not exist—the Association have no information as to that—it would not be unreasonable that the period should not be too long without a break.

5353. By "criticism" do you mean criticism that the trainees are not properly trained, or that the trainers are exploiting them in some way? If so, how is it in their power to do so?—I think it was just a general feeling that

there was a possibility that if a practitioner was recognised as a trainer for an extensive period, the assistant became more of an assistant than a trainee assistant; it was possible that that might happen.

5354. The practitioner cannot increase his maximum list of patients with the trainee assistant, can he?—No, Sir.

5355. You also heard Dr. Baldwin say that, if a practitioner had over a certain number of patients far below the maximum, then he would not be acting as a trainer?—*Dr. Gill*: Yes, that is quite correct. This was just an impression which we of the Association have had. I do not think we have any factual information.

5356. *Sir Hugh Watson*: What you really say in your memorandum is that, in your view, you think this thing ought to be looked at?—It should be looked at, yes.—*Mr. Howie*: There was no information at all that there was any abuse of the system, and there was no doubt that the system was good in principle, but it was felt that this was possibly one way in which criticism could be removed altogether.

5357. *Chairman*: On the whole, would you consider that to be selected as a trainer is a mark of being a bit above the average?—*Dr. Gill*: I should think so, Sir. I think their qualifications are fairly well scrutinised by the Committee who appoint them. It may be of interest if I say that up in the north-east we have difficulty in getting trainers.

5358. Is that due to the kind of people who live in the north-east?—No. I presume that if you have a trainee assistant and are going to do your duty by him, it does mean a certain amount of extra work to the trainer.—*Mr. Hunter*: I think we have the experience in Renfrewshire that conscientious doctors are not able to give the time they would like to the trainee, and they give up the position.

5359. *Sir Hugh Watson*: Dr. Baldwin could not tell us this, but why does a doctor apply to be a trainer?—*Dr. Gill*: One knows that he gets a little extra. He gets about £150 a year extra for training the trainee. There is a training grant given, and even though the practice is small enough for the doctor

to attend to adequately, the fact that he has a trainee allows him a little more leisure. He can, for example, if he wants to go out in the evening, leave the trainee to do the consulting, whereas if he is single-handed he cannot do that. Not only that, I heard Dr. Baldwin say, and I fully agree with him, that having a trainee is a very stimulating experience. It tends to keep the doctor up to date. I had a trainee myself for a year and I found it a very good experience for myself, as well as for the trainee. So I think there are these three points, that you get a little increase in remuneration, you get assistance, and it is a stimulating experience. Also, you know that if you are taken ill in a flu epidemic, the trainee can carry on until you are better.—*Colonel Weir*: I think the average doctor looks upon a trainee as a cut above the average. He is a better than average man, and doctors aspire to be recognised as capable of taking on a trainee. That is the point.

5360. In paragraph 29 you say that you would not object to a different system of remuneration of doctors, if some means could be found of recognising special skill and experience. Do you mean a system entirely different from the present capitation system?—*Dr. Gill*: We simply did not think of any system, Sir. We talked about merit awards, and we all seemed to be against them. We also talked about loadings for a practitioner after, say, age 50 who, because of his increasing experience, might get a higher capitation fee. But we really had no definite suggestion. The other thing that we suggested was that we should load the capitation payments for the very old and very young patients.—*Mr. Howie*: We did not suggest it in our memorandum but it was one of the other things we discussed.

5361. Various suggestions have been made to us for loadings of various kinds; age and experience is one thing, proper facilities—a receptionist, a physio-therapist and so on—receiving post-graduate instruction, attending courses, writing papers, any obvious effort on the part of the doctor to keep himself abreast of current medical thinking and knowledge. But the people who suggested these things did not seem to think they would be very easy to work out.—*Dr. Gill*: That was the feeling we had.

5362. *Chairman*: But those which Sir Hugh mentioned were all assumed to be in addition to a capitation fee system. In your paragraph 28 you suggest that the capitation system is a bad one, and I think in paragraph 29 you go on to say that despite that you can think of no alternative.—We could not think of any other way. We do mention in paragraph 30 that we think there should be some financial incentive to improve premises and to pay for the doctor having ancillary help.

5363. *Sir Hugh Watson*: At the moment, putting it quite crudely, the present system is an inducement to the doctor with a large list to spend the minimum on expenses, as a result of which he gets his remuneration largely net?—Yes.

5364. Have your Association thought of any way of dealing with that?—No, we did not think of any method, Sir. We did suggest that perhaps there might be something to be said for paying the practice expenses separately from the capitation fee.

5365. An objection which has been put to us about that is that it would require the setting up of more machinery to scrutinise expenses.—Yes.

5366. *Mr. Gunlake*: That would be a removal of the present disincentive, rather than an introduction of a positive financial incentive, which is what you said in paragraph 30?—Yes.

5367. That is what you mean, really, the removal of the present disincentive?—Yes, but we have no further suggestions on that consideration.

5368. *Sir Hugh Watson*: The present practice of the payment being an inclusive one, which includes both fee and expenses, makes it difficult.—It does, it makes it very difficult.

5369. *Chairman*: In your experience, do the doctors who scamp their expenses, who provide the minimum of surgery accommodation, waiting rooms and all kinds of facilities, tend to lose patients to those who set a rather higher standard?—I have really no experience of that, Sir. I would not care to answer that, but one must remember that the Executive Councils, through the local Medical Committees, inspect doctors' surgery accommodation, and we do see that a certain standard is kept up.

5370. Yes, but you do know some people whose accommodation arrangements are well above the minimum standard. Do those people on the whole tend to gain any benefit by getting rather more patients? It was put to us in London by one body that in fact that was so, that in fact this raised the standard generally, because the people who tried to work with the minimum facilities found they were losing patients against the better competition.—We have no information on that.

5371. You have no impressions, either, as members of individual Executive Councils?—No, I do not think we have.—*Colonel Weir*: I have heard complaints from individuals that a doctor's surgery was bare and bald, but there was no suggestion that individuals would go to another doctor because of that.—*Mr. Howie*: I think the only point I could add from being concerned with seeing all the surgeries in an area, is that it only needs a start. When one doctor improves his premises the others fairly soon follow on, so presumably there is some advantage to the doctor in having satisfactory premises. On the other hand, it is clear that some doctors do provide a lot of ancillary help, which one would assume must improve the actual standard of the practice, quite apart from the premises.

5372. *Sir Hugh Watson*: You mean in the way of receptionists, a telephone service and a physiotherapist?—Yes. I have only had one experience of seeing a practice with a lot of clerical assistance, and the presence of really adequate clerical assistance would seem very much to enhance the actual medical service. The doctor is able to give a lot more time to his own professional work if his clerical staff is able to relieve him of the routine administrative burdens.

5373. You mean keeping up his practice notes, and that sort of thing, or in filling up the forms he has got to fill up?—Both; and perhaps seeing that the record cards of the patients are before him when the patients enter, which is the kind of thing he finds it difficult to do without clerical assistance. He is setting out to give a really good service in that way.

5374. In other words, he has got a competent secretary?—Yes.

5375. *Chairman*: Presumably, he is thereby able to get through rather more patients thoroughly than he could if he had no clerical assistance?—*Dr. Gill*: Could we say that he is able to spend longer time over them?

5376. Either way. He could presumably choose.—There is no doubt about it that clerical assistance is of the greatest benefit to the doctor, but whether it increases his practice I do not think we have any information.

5377. *Mr. Gunlake*: It might encourage the formation of partnerships. Two doctors might share one receptionist?—Yes.

5378. *Sir Hugh Watson*: On the question of the number of patients a doctor can deal with, in your paragraph 35 you are very emphatic about the need for a reduction in the lists. I do not want to go into this matter in detail, because it is obviously a question of circumstances in each case, but is that the view of practitioners, generally?—We are speaking for Executive Councils, Sir.

5379. I am asking you is that the view of practitioners?—Some practitioners agree with it, other practitioners do not; I think it depends very much on the practitioner. I know in my own area of a doctor with the maximum list, who is a first-class practitioner and gives a first-class service to all his patients. That is recognised not only by his colleagues but also by the consultants to whom he refers his cases. On the other hand, I have had a doctor with a list of only about 1,300 telling me that he did not know how he was going to get through his work. This is just an idea of the Association about the average list, but there are so many variable factors that it is impossible to lay down a hard and fast rule.

5380. *Chairman*: You do go beyond the average. I can well understand as to what the average list should be, but you do say the maximum also should be reduced. The maximum, which is therefore an extreme, must apply to extreme circumstances such as the man you mentioned who manages very well with the existing maximum. Would you really think that that man ought to be compelled to take 1,000 patients less than he does now?—That was just the view of the Association.

5381. Do the Association feel that a man, who is efficiently getting through the maximum list now, ought to have his list reduced by 1,000?—*Mr. Howie*: Paragraph 35 represents, as *Dr. Gill* says, the views expressed to the Association by the 25 Councils in Scotland, but I am sure that in expressing them the Councils would have that difficulty in mind. The real point is that at the moment we have a maximum, and if the maximum is to be reduced there will be hard cases, but certainly Councils generally were of the opinion that the maximum should be reduced. It is of interest to note that the suggested maximum is still above the Scottish average size of list. I think the Scottish average is about 1,984 patients.

5382. But you would always expect the maximum to be far above the average?—Yes, the suggested maximum is considerably above.

5383. *Sir Hugh Watson*: You mentioned a moment ago that the doctor with the large list was known by the consultants to whom he referred patients, and generally known, to be giving a very good service to his patients?—*Dr. Gill*: Yes.

5384. Is it practicable in your view to evolve some system of merit awards for general practitioners?—We could not think of anything at all. Do you have the idea that the doctor's colleagues and the consultants might be the ones who could decide if a merit award was to be given?

5385. I did not say that, but it might be thought I had. You suggested it, you know. You suggested that the consultant was a man who had a very good idea of how the general practitioner looked after his patients. The consultant knows how he presents the patient to him, he knows the standard of presentation of the case history which he gives him, and all that sort of thing.—We could think of no method for giving a merit award. It might be feasible to award an extra payment on the lines that you suggest, but we did not think of it.

5386. *Mr. McIntosh*: But you have machinery for selecting trainers?—Yes, we have the Committees which select trainers.

5387. *Sir Hugh Watson*: What *Mr. McIntosh* has in mind is that, if you have a Committee which can assess the merits of doctors to the extent of judging that they are suitable people to have trainees, you might also have a Committee which might be suitable to judge whether a doctor ought to get some extra remuneration.—I suppose that is feasible, *Sir*.—(*Mr. Howie*): Our difficulty has been that all the Councils have recognised that the present position is to some extent unsatisfactory for the reasons we have stated, for the reason that the man with the biggest list and the lowest expenses would seem, on the face of it, to gain the most; but whatever the solution might be the Association could not suggest one. There was a general and quite strong feeling against merit awards as these at present operate in the hospital service. The objection to that system seems to be, generally, lack of information and the feeling it might not operate equitably. But that is something the Association have no information about, except that they have a generally and quite strongly held opinion that, if there is to be any system of recognition of special skill and experience, it should not be on these lines.

5388. In paragraph 37 you stress quite forcibly that since the inception of the National Health Service the load of work falling on general medical practitioners has considerably increased. I think this is the most forthright expression of view we have had about this matter. Can you elaborate a little?—(*Dr. Gill*): That was the impression of the constituent Councils when they wrote in, but I do not think we have any actual figures which we can produce to substantiate that statement.—(*Mr. Howie*): We made a great many attempts to get some really satisfactory comparable figures. Our main difficulty is to get sound figures for pre-Health Service days. A doctor always finds difficulty in estimating the size of his private practice prior to 1948, because he did not quite know how many people he was at risk to attend. We have made many attempts to get good figures since the memorandum was lodged, but it would seem that possibly we have erred in committing to writing the view, which was generally expressed, that the load of work has almost doubled. It would now seem that there has probably been little

change in the number of items of service which a doctor gives to a Health Service patient today, who was previously an old panel patient prior to 1948. The real increase lies in the number of items of service which a doctor gives to people who, prior to 1948, were the dependants of insured people; on that there seems to be a very substantial increase.—(Dr. Gill): We also felt that, not only was there some increase in the number of items of service, but there was also an increase in the time taken over the individual patient, because we felt that medicine is becoming a more exact science, and cases which formerly were shot off into hospital are now being treated at home. The doctor has added responsibility nowadays. Taking the maternity service, for example. To look after a maternity case properly nowadays it is necessary to see the case early on in the confinement, to check bloods for rhesus factors, to check the blood pressure and keep a very close eye on the patient, whereas formerly the ante-natal care was very sketchy indeed. So not only have the items of service gone up, but also the load of work, the time spent and the responsibilities of the doctors. Another example is the treatment of tubercular meningitis. In the pre-streptomycin days the later you diagnosed a case of that type the better, because you did not worry the parents about whether the child was going to die, but nowadays it has got to be diagnosed at the very beginning if that child is going to be all right, so there is very much more responsibility.

5389. These matters, to which you referred very properly, about the increase in ante-natal care could be reflected in some system of payment by items of service?—Yes, they could be, Sir.

5390. They all amount, from what you have told us, to items of service. You know, of course, that dentists are paid on an items of service basis?—I was trying to make the point that, not only have the items of service increased but also the responsibilities attached to the items of service. They are also higher than formerly.

5391. Yes, I can see that. I was wondering whether, in view of what you have told us, the increased responsibility of the doctor might not be more properly compensated for on an items of service

basis, than on a mere capitation basis.—I think that would be a good idea.

5392. *Chairman*: Payment for maternity services is on an items of service basis now, is it not?—No, the only allowance is 7 guineas for looking after the case all through the pregnancy, confinement, and post-natal period, irrespective of the number of attendances or visits which are given.

5393. There is a certain minimum, is there not?—Yes, Sir.

5394. It is not a capitation fee. It is the nearest which I think you have got to an items of service payment.—Yes, it is.

5395. *Sir Hugh Watson*: Dr. Baldwin told us about hospital experience in general practice. Would you agree that a not too long hospital experience along the proper channels, as he put it, was a good thing for the general practitioner to have?—Yes. We dealt with that in paragraph 42 and we said that most Executive Councils do prefer the candidates to have a certain amount of hospital experience, but not too much, because we feel that if the candidate has been too long a time in hospital his experience has tended to become too specialised.

5396. That is what Dr. Baldwin meant when he said that he, as a general practitioner, would like his colleague to have had training in hospital in some subject which would be useful to him in general practice?—Yes.

5397. You say in your paragraph 40 that Councils look for broad experience in general practice and hospital work. How exactly would you define broad experience?—What we mean is that if an applicant told us he had spent a year as a House Surgeon, perhaps, in a chest unit, we would not look at his qualifications so favourably as someone who had, perhaps, spent a year in five or six different departments of the hospital.

5398. Is that a thing which it is feasible to do? Can that be arranged?—It is compulsory to spend so long on the medical side of the hospital, and so long on the surgical side of the hospital.

5399. That is during their compulsory year?—Yes, and then after that it is possible in some appointments to look after three of the smaller specialties at the same time. For example, I think in Aberdeen the House Surgeon of the

Malignant Diseases Ward also looks after the dental patients and the skin patients during his term of office. He has three chiefs.

5400. Is that during a further period of six months that he is there?—Yes. I think the Executive Councils would prefer them to have their compulsory year and perhaps a year after that, after their military service.

5401. You mention in paragraph 46 the combined training in general practice and hospital work, and you approve of that.—Yes, I think it is a good idea. It is unfortunate that Mr. McIver, our former President, is not able to be here, because it is working very successfully up in Inverness.

5402. In your memorandum you do not, as far as I know, say anything about inducement payments for doctors.—No, we do not mention that.

5403. You do suggest the possibility of such payments for dentists, but you do not mention doctors. Do you find these payments sufficient? Dr. Baldwin and his colleagues told us something about them, and how they are administered.—We certainly think that they are absolutely essential, but we did not consider whether they are sufficient because, after all, the Executive Council only pays over the inducement payment which has been arranged by the Medical Practices Committee and the Department of Health. We have no say in the actual amount.

5404. *Chairman:* But the question of sufficiency really means do you get the right number of doctors in those out of the way places with very scattered populations?—Yes, I think we can see that from Appendix 2, dealing with the number of applications for the various vacancies. If you look at Orkney and Zetland, which are fairly isolated, you will notice that for the small Orkney practice with 170 patients there were six applicants. A list of that size, without an inducement payment, would be entirely uneconomical, to put it very mildly.

5405. *Sir Hugh Watson:* That does seem to show, as you indicate, that the system is working satisfactorily.—Yes.

5406. Have your Association and its constituent Councils any view about any relativity which ought to obtain as to the remuneration of doctors and dentists?—*Mr. Howie:* The only evidence

given by the Association, which seems in any way to bear on that subject, is the information in regard to the earnings of medical and dental assistants in Appendices 8 and 10. That information seems to show that on the whole the dental assistant is better paid, but that is probably simply because he is in short supply. So far as the general relativities are concerned, the Association of course have always been anxious to make it clear that they are not directly concerned with rates of remuneration.

5407. Then you would rather pass from this question, Mr. Howie?—There were certain points we noted and the first one was that it appeared that the demand is such that a dental practitioner can obtain substantial earnings immediately after qualification, and the young doctor after qualification has still to become established. We have spoken of the difficulties he has in that connection. According to statistical information published by the British Dental Association—and it was submitted to the Royal Commission—the earning peak of the dental practitioner in Scotland is reached before he is 35. Then there is this very rapid and serious decline in his earnings after that period. The Association thought it was to some extent attributable to the physical demands of dental practice. The other point is that while a young doctor takes longer to reach his earning peak, he does not seem to suffer this rapid decline, and his earning pattern is a much more consistent one. Another thing which we thought was of importance was that the dental practitioner, reaching his peak earlier, is bearing heavy taxation in those years of high earnings, but the doctor's earning pattern is much more consistent and, presumably, his taxation is much more evenly spread. But on the general question of relativity, I do not think the Association had any more information which they thought fit to give.

5408. Nor have they any view on the matter?—No, Sir, we just felt that any true comparison of the earnings of a doctor and a dentist would need to be taken over a professional lifetime, because of this age factor which seems to affect earning capacity.

5409. The Spens Committee made some attempt to express a relativity, as you know, but you would rather not express a view?—No, Sir.

Chairman: But you realise we have taken a very broad sample from both professions, and we know the actual earnings at a wide variety of ages of a large number of people.

5410. *Sir Hugh Watson:* Have your Association any ideas about the method of remuneration which should be introduced so as to encourage dentists to go to remoter areas?—*Dr. Gill:* We did suggest there should be an inducement payment similar to what the doctor gets, to try and make it economic for a dentist to go to the more remote areas.

5411. *Chairman:* Does this mean you are really short of dentists in the remote areas?—Yes, very, very short indeed.

5412. Shorter even than you are elsewhere?—Yes.—*Mr. Howie:* I think our concern, in the first instance, is the barrier which at the moment stands between the person in an isolated area of Scotland, and a complete National Health Service. The National Health Service is only available freely to people who stay within a reasonable distance of the Service. There can be no doubt that many people in the North of Scotland are denied a free Health Service. They are put to very considerable expense, particularly in order to obtain dental and ophthalmic treatment, and presumably in many areas they are denied that treatment because of the difficulty of getting to it. Our Association have felt, and at our annual conferences in the past one or two years it has been very strongly expressed, that the Service must be taken to these people; that it must be as easily available to a man in Caithness—perhaps not as easily available, but as freely available in the financial sense—as it is to a person in Edinburgh. That is not so at the moment, and it seemed to follow from that that, if the services are to be taken there, the practitioner must be induced to go there. The Association are still conscious that, with a national shortage, to take a dentist to a remote area is going to denude another area, but we felt that if there was a national shortage then it must be nationally spread over.

5413. *Mr. Gunlake:* Is it possible for a dentist to have, say, five surgeries in a remote area and spend one day a week in each?—Yes, but the difficulty there is that, whereas a medical practitioner is

paid on a capitation rate and his earnings continue, the dental practitioner's earnings cease when he starts to travel.

5414. *Chairman:* But you would suggest covering that by some inducement payment of a lump sum, variable according to the district, would you?—Yes, Sir. We felt there must be some method of taking the dental practitioner and the ophthalmic practitioner to these areas, without him suffering hardship. We cannot expect that he should lose, in order to take to the people the service which the country is in effect under obligation to give to these people.

5415. *Sir Hugh Watson:* Of course, so far the country has not undertaken to provide a free dental service. It has undertaken to provide payment for what dental service the population can get, but so far as I know it has not undertaken to provide a free dental service.—Without lists of patients, as we have in the case of doctors, that is in theory correct. I would suggest with respect that it is a very theoretical thing, and the Health Service is truly under an obligation to take the appropriate services to the people, whether or not we have lists of patients, or whether or not we pay the person for an item of service.

5416. What you are really saying is that the Health Service is morally bound to do this?—Yes, and it is not at the moment doing it.—*Colonel Weir:* There is a definite tendency for young dentists to put themselves down in the new towns which are being established, and they will not go out to the sparse western areas.—*Mr. Howie:* That is, of course, attributable to the fact that in all areas there is still a shortage. And of course, there is no doubt that to establish oneself near centres of education is convenient for one's family, etc. But, nevertheless, there is also the other point of view. Can a man be reasonably expected to go to a remote area when not only are there family considerations which affect him, but also very pressing financial ones?

5417. *Chairman:* Broadly, you feel there must be the same sort of encouragement as doctors have, which will make dentists go of their own free will to these sorts of areas?—Yes. That is one matter on which the Association feel most strongly. During the last three years at our annual conferences we have

come back to this time and time again, that the Health Service is not nationally fully available.

5418. And is it a matter of, say, 100 dentists or less, that you would like to see induced by payment to go to these parts of Scotland?—I would not know the number. It cannot be any great number.

5419. *Sir Hugh Watson*: It is going to be very difficult, is it not, to find a system of payments which would induce people to go to these remote areas, which have the disadvantages you mentioned a moment ago about education and other similar things, when they can earn such very large sums in the large centres of population?—There are other compensations to take people there. There are some areas which are in themselves attractive. For instance, one sees that doctors can be reasonably induced, without a great burden on the Exchequer, to go and give essential services in Orkney. Presumably Orkney in itself is attractive to the doctors; but they still could not go there but for the fact that they were guaranteed a reasonable standard of living.—*Dr. Gill*: The other method would be an adequate payment to compensate them for travelling. As Mr. Howie pointed out, when a dentist is travelling his payment ceases. If adequate payment was added, he might leave the more populous areas and travel out. With air travel nowadays he might be able to go to some of the more remote isles, if he was properly paid to do so.

5420. *Mrs. Baxter*: In this case, he would do this one or two days a week, whilst retaining a practice in the centre, as well?—Yes, and that already applies. There are a number of Aberdeen dentists who go out to the periphery, consulting half a day a week or half a day a fortnight.

5421. *Mr. Gunlake*: And they have to find equipment then for two or three surgeries?—They carry equipment, such as a portable drill, with them.—*Mr. Howie*: I have extracts from the report of the last meeting:

"Dr. Wilson of Inverness, referring to the position in North and South Uist, Benbecula and Harris, said there was a dentist in 1948 who was admitted to the list. He resigned in 1951. He was the only dentist and left a great

deal of incomplete work. The second dentist was admitted in 1951 and took over the incomplete work. He resigned in 1953. He had previously been associated to some extent with the school dental service, because the local authority were having difficulty in providing a school dental officer. Then the school dental service, which was most co-operative in this matter, agreed to advertise for a dentist jointly with the Executive Council, payment to be made half by the local authority and a guarantee for the remainder to be given by the Executive Council."

That was to some extent going towards an inducement payment.

"A dentist was obtained in 1953. He intimated his resignation in 1955. Again this joint post was advertised, the net income from all sources being £1,000. We received no applications in the first place. Then we received one or two which were not thought suitable. Later we had another one or two applications and one of the applicants was appointed but withdrew before coming. For two years until 1957 these Isles were completely without a dentist. At last, having raised the guaranteed salary to £1,575, a dentist was obtained who took up duty in March of this year. He has now sent in his resignation and is leaving in November. Once again we are faced with the fact that there will be no dentist there."

At the same meeting, a representative from Argyll and Bute said:—

"We have an altruistic Glasgow dentist who flies and sometimes travels by boat to Mull and Tiree. He does so for expenses only and he provides a very good service. How long it will go on, I can't say. We have a dentist in Islay who is over 80. How long he will go on, I can't say. Within the last month, we have lost two dentists out of three in Campbeltown. It seems to me that a more enlightened policy is required."

5422. *Sir Hugh Watson*: In your paragraph 54 you suggest that some special payment should be made to dentists for special skill and experience. That sounds rather like a merit award. How would you suggest that should be worked?—*Dr. Gill*: Again, as in the case of the doctors, we find it very difficult indeed to devise a solution. We did think a payment ought to be made,

and possibly it should be done by loading certain more specialised forms of treatment, for example, or loading the payment to dentists after a certain age. Those were the main ideas we had.

5423. It seems rather anomalous to load a dentist after a certain age, when you take the view that his output is going down.—Yes, but the reason is that he is no longer quite so fit to carry on with the very high speed and highly delicate work. By doing less work he is equally able to carry on even to 80 in some cases.

5424. It might be difficult to convince the Treasury that that was a proper way to bolster up a man whose output was understandably but definitely decreasing.—But then we would say that, although he was not able to work at the same high pressure, the work that he did would probably be better because of the experience he had acquired during his life's work.

5425. Would you make that available automatically to dentists of a certain age, or how would you decide who was to get it?—Again, we had not thought of that any more than we had with the doctors.

5426. *Mrs. Baxter*: Surely, difficulty would arise if a dentist continued to drive himself and take a large number of patients?—We would not put anything in his way. It is the dentist, who does it himself. We do not say "You must do less". We leave him to carry on as he feels able.

5427. But pay him more for carrying on as his years increase?—That would be available to anyone after the age of 50, but the other thing was that we should load certain more skilled procedures.

Mrs. Baxter: That is rather different.

5428. *Chairman*: You are thinking rather more in terms of 50 as being the age at which a dentist's skill declines, rather than 35, are you not?—I am just using 50, but the information we have is that it goes down after 35. We have no information apart from what we are given.

5429. *Sir Hugh Watson*: Would you suggest taking something away from the new dentists and giving it to the older ones?—No, I do not think we should.

—*Mr. Howie*: I understand that the scale of fees at the moment includes the

skill element. The Association merely felt it was something to which they would like to direct attention, without unfortunately being able to suggest a solution to it. But they did feel that in some way the answer might lie in the recognition of the skill involved in special procedures.

Sir Hugh Watson: That should not be too difficult because, as you know, this was all gone into by a Working Party, and the times which the average dentist ought to take for any particular dental operation were laid down as a result of that Working Party's deliberations. I would suppose that, if there are some operations which require special skills, then another Working Party could deal with that. That would seem to me to be a reasonable suggestion of yours. I do not think I have any more questions, Sir.

5430. *Chairman*: I just want to come back to one point on your paragraph 35. In the middle of that paragraph you say: "The permitted increase in respect of the employment of an assistant should be in the region of 1,000 patients." I take it that when a doctor first has an assistant he does not immediately get his full extra list. He takes two or three years to work up to it?—*Dr. Gill*: Yes, Sir, and it does not necessarily follow that his list will go up to that number.

5431. If the maximum he can ever have is 1,000, you will realise the maximum income he can get from that at the very top is probably going to be just about level with the salary he pays out. Will any doctor ever take an assistant on this basis?—Yes, Sir, I think they do. Doctors who are well within the permitted maximum take assistants, because they find that it enables them to practise better medicine; it enables them to take things a little easier and have a little time off. It is not only from the point of view of increasing one's remuneration. There are certain other very definite advantages to the principal in taking an assistant.

5432. But if money is a consideration to the principal, he would find it unprofitable to employ an assistant?—Yes. Their permitted maximum at present is 3,500.

5433. The permitted extra for an assistant is 2,000?—Yes, Sir, but the

permitted maximum at present is 3,500. There are many doctors who have lists of only 2,500 who employ an assistant, because I feel that to look after 3,500 properly means devoting one's whole time to it. The doctor to whom I referred started about 8 o'clock in the morning and finished about 9 or 10 at night, and that was his sole interest and his sole hobby. Not all of us are quite so hardworking as he is.

5434. No, but you are suggesting a limit.—We are suggesting a limit to the number of patients which an assistant can attract.

5435. And that should be in the region of 1,000?—The number we suggested was in the region of 1,000.

5436. Whereas, if the man is taken in as a junior partner, there can be straightaway the full additional amount of a principal, which is a very much larger figure?—Yes.

5437. Are there any more things that you wish to add in the light of anything that we have said?—No, I do not think so.

Chairman: I think that concludes this session. Thank you very much for coming and answering our questions so fully.

(The witnesses withdrew)

Scottish Association of Executive Councils

ADDITIONAL INFORMATION FOR THE ROYAL COMMISSION ON DOCTORS' AND DENTISTS' REMUNERATION

(see Q. 5340-5341)

EMPLOYMENT OF ASSISTANT MEDICAL PRACTITIONERS

See Appendix 8 (page 2) of the Association's Memorandum of Evidence to the Royal Commission

At their hearing in Edinburgh, the members of the Royal Commission noted that in certain practices assistants had first been employed in the years 1948, 1949 and 1950. The figures are as shown below. The Association were asked to enquire whether in these practices assistants had been continuously employed.

<i>Assistant First Employed</i>	<i>No. of Practices</i>
1948	46
1949	16
1950	22

The enquiries of the Association disclose:—

46 Practices first employing assistants in 1948

These practices in the 10-year period to 1958 have employed assistants thus:—

<i>No. of Practices</i>	<i>Years throughout which assistants employed</i>
34	10
1	9
1	8
5	7
1	6
1	5
2	2
1	1
—	—
46	
—	—

16 Practices first employing assistants in 1949

These practices in the 9-year period to 1958 have employed assistants thus:—

<i>No. of Practices</i>	<i>Years throughout which assistants employed</i>
10	9
2	8
2	7
1	6
1	1
—	—
16	
—	—

22 Practices first employing assistants in 1950

These practices in the 8-year period to 1958 have employed assistants thus:—

<i>No. of Practices</i>	<i>Years throughout which assistants employed</i>
16	8
2	7
1	6
1	5
2	4
—	—
22	
—	—

Royal Commission on Doctors' and Dentists' Remuneration

MINUTES OF EVIDENCE

23

Twenty-Third Day, Thursday, 22nd January, 1959

WITNESSES

British Medical Association

LONDON

HER MAJESTY'S STATIONERY OFFICE

1959

FIVE SHILLINGS NET

Witnesses

BRITISH MEDICAL ASSOCIATION

S. WAND, M.B., Ch.B.

H. H. LANGSTON, F.R.C.S.

J. R. NICHOLSON-LAILEY, F.R.C.S.

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MINUTES OF EVIDENCE

TAKEN BEFORE THE

Royal Commission on Doctors' and Dentists' Remuneration

TWENTY-THIRD DAY

Thursday, 22nd January, 1959

Present:

SIR HARRY PILKINGTON (*Chairman*)

MRS. K. M. C. BAXTER

MR. A. D. BONHAM-CARTER, T.D.

MR. J. H. GUNLAKE, C.B.E., F.I.A.,
F.S.S.

PROFESSOR JOHN JEWKES, C.B.E.

MR. I. D. MCINTOSH, M.A.

SIR DAVID HUGHES PARRY, Q.C.

SIR HUGH WATSON, D.K.S.

MR. S. WATSON, C.B.E.

MR. W. A. FULLER, D.S.C. } *Joint Secretaries*
MR. J. B. HUME }

FIRST SUPPLEMENTARY MEMORANDUM OF EVIDENCE

*presented by the British Medical Association to the Royal Commission on
Doctors' and Dentists' Remuneration, March 1958*

(1) THE NEED FOR REVIEW

1. The Council attaches the greatest importance to Part (c) of the Terms of Reference, which invites the Royal Commission to consider "whether, and if so what, arrangements should be made to keep [that] remuneration under review."
2. Whatever the Commission's ultimate recommendations on current levels of remuneration, the continuing changes which take place in economic and other conditions of themselves necessitate the introduction of special arrangements to ensure that medical remuneration in the future is kept continuously under review.
3. The history of the profession's negotiations with the Government over the past 45 years has already been referred to in the Council's Preliminary Memorandum of Evidence. The unhappy series of events described in that document demonstrate beyond doubt that if similar disputes, which in the past have often been settled on grounds of expediency rather than merit, are to be avoided in the future some special machinery must be established for the purpose. It is not the wish of the profession that the Government should periodically be confronted with claims for increased remuneration, but experience has shown that in spite of obvious declines in the value of medical remuneration the Government itself has never come forward of its own volition with proposals to remedy the situation, as was surely its duty, and the profession has been compelled to take the initiative. The long and bitter disputes which followed are helpful to neither side, are not in the public interest, and are particularly frustrating to the medical profession.
4. The Council therefore believes that the Commission will be making a notable contribution to better relations between the Government and the profession if it

sees fit to recommend a conciliation machinery acceptable to both parties and designed to ensure that difficulties and differences of opinion in the future are settled without the need for protracted and acrimonious disputes.

(2) EXISTING METHODS OF NEGOTIATION

5. Before submitting its own proposals on the subject the Council feels that it would be helpful to the Royal Commission to know how the present systems of negotiation in the various branches of the profession evolved and to have its attention drawn to the defects which experience has brought to light. The ultimate failure of the present machinery is illustrated by the appointment of the Commission itself, but without some detailed knowledge of past and present negotiating machinery it would be difficult for the Commission to judge the extent to which that machinery has failed and so make constructive suggestions for the future. The following paragraphs, therefore, trace the development of the existing negotiating machinery and focus attention upon those failings which the Council feels must be avoided in the future.

Negotiations prior to the Appointed Day

6. Up to the Appointed Day negotiations on behalf of the three main sections of the profession—general practice, consultant practice, and the public health service—were carried out in the following way:

General Practice. Negotiations on the terms and conditions of service in the National Health Insurance scheme took place direct between the Ministry of Health and the Insurance Acts Committee of the Association, the latter acting in its dual capacity as the Executive of the Conference of Local Medical and Panel Committees and as a Standing Committee of the Association. So far as activities outside the scope of National Health Insurance were concerned, and apart from purely private practice, which remained a matter for private arrangement between the doctor and the individual patient, negotiations were conducted by another Committee of the Association (the General Practice Committee) with the various Government departments and other organizations concerned.

Consultants and Other Hospital Staff. Prior to the Appointed Day, in the case of voluntary hospitals there were no negotiations on a national basis on the terms and conditions of service for hospital staffs. The salaries for staffs appointed to hospitals administered by the local authorities came within the scope of the arrangements for the Public Health Service. The then Hospitals Committee of the Association, together with the various specialists groups, held a watching brief over the activities of the voluntary hospitals.

Public Health Service. The negotiating machinery in the Public Health Service came into being in 1929, following a conference under the chairmanship of Lord Askwith, on the subject of the Terms and Conditions of Service for doctors employed by local authorities. This conference made a number of recommendations, and the scales suggested, although not mandatory, were, generally speaking, subsequently adopted by the various local authorities. There were a number of interim revisions of the Askwith recommendations—all achieved by means of agreements reached between representatives of the Association and the local authorities.

Negotiations since the Appointed Day

7. Following the introduction of the National Health Service in 1948, responsibility for separate negotiations on behalf of the three main branches of the profession fell to:

- (1) The General Medical Services Committee (which replaced the Insurance Acts Committee) representing general practitioners;
- (2) The Joint Consultants Committee, consisting of representatives of the Central Consultants and Specialists Committee (which replaced the Hospitals Committee) and the Royal Colleges and Scottish Corporations, representing hospital medical staffs, and

- (3) The Public Health Committee (upon which there is direct representation of the Society of Medical Officers of Health) representing medical officers in the Public Health Service.

The first retained the system of direct negotiations with the Ministry of Health, whilst the other two sections proceed to conduct their negotiations through Whitley Council.

The Evolution of the Medical Whitley Council and Committees A, B, and C

8. In October, 1947, the Association accepted an invitation from the Ministry to discuss the establishment of a Medical Whitley Council to deal with Terms and Conditions of Service for doctors taking part in the National Health Service.

9. The Association maintained that Whitley machinery for the medical profession should be kept apart from any machinery set up for National Health Service employees as a whole, and this view was repeated in May, 1948, following the circulation by the Ministry of a revised draft of the main General Whitley Constitution which did not give the Medical Functional Council the degree of independence which had been sought. The Ministry, however, would not agree to any entirely separate machinery for the profession outside the General Whitley organization.

10. In September, 1948, representations were again made by the Association—this time to the effect that the Medical Functional Council and any Committees that that Council might establish should be independent of the proposed General Whitley Council. The Ministry then clarified the role which the General Council would play, and the plan was accepted by the Association following an undertaking by the Ministry that "all matters on Terms and Conditions of Service for doctors participating in the National Health Service—other than those which it might be agreed to be matters for direct agreement between the profession and the Minister—fall to be decided by the Medical Functional Council without the need of confirmation or ratification by any other body." This position, giving the medical profession virtual independence within the general Whitley structure for the National Health Service, has been maintained and has never been effectively challenged by the General Whitley Council.

11. The Association in November, 1949, following consultations with the various organizations concerned, appointed the Staff Side members on the Medical Whitley Council and Committees A, B, and C. The representatives on the Committees, and thence the Medical Whitley Council, were appointed respectively by the General Medical Services Committee, the Joint Consultants Committee, and by the Council on the recommendation of the Public Health Committee. A diagrammatic presentation of the organization appears in Appendix A.

12. *The full Medical Functional Council* has met on three occasions, when purely formal business was transacted.

13. *Committee A* has not functioned, though technically it is in being, and its members are reappointed each year.

14. *Committee B* has met regularly, and many changes in the terms of service for members of hospital staffs have been negotiated and agreed. On two occasions where agreement could not be reached in Whitley it was agreed to refer the disputes to arbitration in the Industrial Court. In these cases the ruling of the Court was accepted by both Sides, thus constituting a formal "Whitley agreement," and these have been implemented by the Ministry, Regional Hospital Boards, Boards of Governors, and Hospital Management Committees.

15. *Committee C* has met regularly. In the preliminary period during 1950 and 1951 prolonged discussions on the remuneration of Public Health Medical Officers broke down and finally ended (*by agreement*) in arbitration in the Industrial Court. In all the matters referred to arbitration, both Sides accepted the Court's rulings and the recommendations were incorporated in a formal Whitley agreement which was recommended for implementation to local authorities. The great majority of local authorities now automatically accept and give effect to Whitley "C"

agreements but there was in 1951 a hard core of local authorities who declined to take the necessary action. These were ultimately resolved by means of the Whitley Appeals machinery.

History of Negotiation under the National Health Service

16. Thus, at the present time, there are two distinct methods by which the profession conducts its negotiations on terms and conditions of service with the Ministry of Health—in the case of general practitioners directly with the Minister or officials of the Ministry, and in the case of hospital medical staffs and medical officers in the public health service through the appropriate Committee of the Medical Functional Council. In practice, neither method has been completely satisfactory, and the following two sections of this Memorandum draw attention to some of the defects in both methods of negotiation.

Direct Negotiation with the Ministry of Health

17. In following the practice of its predecessor, the Insurance Acts Committee, of conducting negotiations direct with the Ministry of Health, the General Medical Services Committee has continued a system which has in many respects proved its value over a long period of years.

18. The essence of negotiation in the field of general practice is that the Committee approaches the Ministry whenever the occasion demands, and the Ministry is equally free to seek the views of the Committee whenever the need arises. Negotiation is quite informal, and representation of either side is on an *ad hoc* basis. The whole system is extremely flexible, and there is no doubt that on day-to-day questions affecting terms and conditions of service of general practitioners in the National Health Service this method has given general satisfaction and has enabled many problems to be resolved both speedily and amicably.

19. Unfortunately, the same cannot be said of problems which had major financial implications. Whilst it is true that the General Medical Services Committee has always enjoyed access to the Minister of Health, there is no provision for arbitration should the need arise. The Minister can, and indeed does, reach arbitrary decisions unrelated to the merits of the case, and the profession is left without any form of redress.

20. The Council has always maintained that there should be some impartial body to whom disputes of this nature can be referred and whose decisions would be binding on both parties. If general practitioners could be sure that an outstanding dispute between their representatives and the Ministry of Health could be resolved in this way many understandable feelings of frustration and grievance would be removed. It is true that the Government agreed to independent adjudication in the case of the dispute which finally culminated in the Danckwerts Award. Nevertheless, this was only after years of wrangling and proved to be a procedure which the Government has since refused to repeat.

21. It is wrong that anyone, even a Minister of the Crown, should be judge in his own cause, particularly so in this case in view of the special circumstances in which the medical profession entered the Service. The absence of independent arbitration is a major defect in the present negotiating machinery in general practice.

Negotiation in Whitley

22. Negotiations on terms and conditions of service carried out by the other two main branches of the profession—hospital medical staffs and medical officers in the public health service—take place in Committees B and C respectively of the Medical Functional Council, and experience has shown that they too suffer from a number of defects. It is, however, possible for criticism in these fields to be far more specific, for the machinery is formal and some of the defects of Whitley can well be attributed to the rigidity of the machinery itself. Some of these defects are summarized below:

1. *The Influence of the Ministry and the Treasury*

23. Theoretically, the Management Sides in Whitley consist of the representatives of the various employing bodies, but in actual fact, on major issues involving finance,

the Staff Sides have gained the impression that proposals are not considered on their merits but in relation to extraneous considerations, such as the impact that they may have upon the economic situation generally.

24. Indeed, the manner in which the recent interim adjustment was made in the remuneration of hospital medical staffs is a good example of the way in which the Government can give effect to a unilateral decision on a matter which, though affecting the Terms of Service, was never discussed with the profession nor considered in Whitley.

25. Again, the regulations which give the Minister power to approve, or disapprove, changes in the terms and conditions of service negotiated through Whitley mean that the Minister, as the ultimate paymaster, has, through his officers, the opportunity of influencing the course of negotiation to a large degree, whilst reserving to himself the power of subsequent veto. This state of affairs must inevitably prejudice negotiations in Whitley from the start.

26. Until quite recently the Minister had never taken the extreme step of exercising his power of veto, and whatever the merits of the recent Whitley agreement on the salaries of clerical staffs in the National Health Service (with which the medical profession is not directly concerned), the Council is profoundly disturbed on a point of principle, that agreements in Whitley can at any time be vetoed by the Minister. The necessity for putting this power in the hands of the Minister was challenged at the time that the regulations were introduced. The Ministry, in a letter dated August 4th, 1951, to the Chairman of the Staff Side of the General Whitley Council, stated:

"The Minister wishes to say that the object of the regulations is to enable a more solid legal foundation to be given to national rates of pay and other conditions of service and to ensure the application of such rates and conditions by hospital authorities. The regulations do not supersede in any way the work of the Whitley Councils in regard to remuneration and conditions of service in the National Health Service and the Minister would not wish the Whitley Councils to be in any doubt on that score."

Thus, powers taken by the Minister under one guise have been used for an entirely different purpose. Furthermore, the profession's confidence can hardly have been strengthened by the Prime Minister's statement on December 23rd, 1957, to a deputation from the Staff Side of the General Whitley Council that "the Government could not be bound by the undertaking of a former Minister of Health in time of crisis." It seems to the Council that the Minister's over-riding powers—and it is now clear that the Government intends to use them—completely negate the whole principle of collective bargaining in Whitley, and the medical profession can therefore have no confidence in it where major disputes on remuneration are concerned.

2. Lack of Proper Negotiation

27. Theoretically, Whitley machinery should provide the means whereby both sides state their case and, by a process of give and take, reach a solution which is acceptable to both. In practice, and particularly on major issues involving finance, negotiation in the true sense of the word does not occur. The firm impression has been gained by the Staff Sides from discussions which have taken place that the Management Side have agreed to a particular line of action prior to meeting the Staff Side and, without further private consultation, have felt unable to retreat from the position they have taken up. Thus the proceedings take the form of an offer or claim being made by the one side and its rejection or acceptance by the other. The discussion is normally restricted to one spokesman on either side, and the cut and thrust of debate which takes place in direct negotiations with the Ministry is largely absent.

3. Arbitration

28. The present position in Whitley of arbitration only by agreement means that neither Management Side nor Staff Side can go to arbitration independently. Although Whitley by precedent is an established route to the Industrial Court, recourse to the Court by the profession is possible only with the consent of the

arbitrable level. The Priestley Commission received evidence both from the Staff Side organizations and the Treasury advocating the introduction of some form of machinery for the independent review of remuneration in these grades, and the Commission's recommendation, which was accepted by the Government, was that for this purpose a Standing Advisory Committee should be appointed by the Prime Minister after informal consultation with the staff interests.

43. In order to discharge its task, this Standing Advisory Committee (the Review Committee) is provided with factual material collected by a fact-finding unit set up for the purpose and in which the staff associations concerned participate. Fact-finding is a continuous and detailed study carried out at first hand by qualified and experienced staffs. The fact-finding unit is concerned with establishing job-comparability and the collection of information on pay and conditions, and confines itself to assembling and listing strictly factual matter.

44. The Council appreciates the advantages in the kind of review body recommended by the Priestley Commission for the purpose for which it was recommended—namely, review of the salaries of the higher civil servants. No proper comparison can be made between these civil servants and members of the medical profession. The position of the higher civil servants as essential advisers and executives of Ministers and Government departments and the clear necessity for the Government to ensure, for the sake of its own efficiency, that the right men are obtained and retained in a contented state of mind, all make it very unlikely that the Government would neglect to give effect to recommendations of the review body.

45. In the case of the medical profession there has been no encouragement for the belief that Government would give effect to any recommendations made by a similar advisory body charged with the duty of reviewing medical remuneration. Apart from this fundamental difference between the position of the profession and that of the higher civil servants there are certain unacceptable features of the Civil Service machinery. For example, it is understood that the Standing Advisory Committee is not required to review remuneration at stated intervals but can do so on its own initiative or at the request of the Treasury. Action cannot be initiated by the representative organizations of the officers concerned. Again the Committee itself is only an advisory body.

46. The Council must press for a formal arbitration procedure on major questions of remuneration unless it is possible to devise some means of preventing disputes in this field from reaching the stage at which the cumbersome machinery of arbitration needs to be invoked.

47. For example, if it can be agreed that, following changes of agreed dimensions, commensurate adjustments should be made, negotiations, disputes, and arbitration would be unnecessary. All that would be needed would be a determination of the amount of the adjustment required.

48. The suggestions which the Council sets out below would, in fact, freeze remuneration, once agreed, for a period of three years—except where a major change has taken place, and even in that case the freeze would operate for one year. The Council appreciates that in an inflationary era the medical profession will always be behind in its remuneration, but even so it is prepared to accept this if procedure can be agreed to keep medical remuneration under constant review.

49. The Council wishes to emphasize that the suggestions which follow have been designed solely in the light of the existing structure of the National Health Service. It should not be taken that the procedure recommended would necessarily be appropriate if radical changes were to be made in that Service.

The Recommended Procedure

50. It is recommended that a Standing Committee on medical remuneration be appointed by the Prime Minister. The Committee would be quite small and under the chairmanship of an eminent person possibly with a legal background; its composition would be agreed with the medical profession. The terms of reference of

the Committee, also to be agreed with the profession, would be to review remuneration in the medical profession at annual intervals and to make a report to be issued publicly each year. The basis of the annual review would be movements in an index, the details of which would be agreed between the Government and the profession. The Council has taken expert advice on the subject and has been assured that such an index could be devised without difficulty.

51. The Committee would be open to receive representations from either the Government or the profession at any annual review. The Council does not feel that the adoption of this review procedure should rule out the right of either the Government or the representatives of the profession to make representations to the Committee on any matter arising on the general question of remuneration.

52. Though there would be an annual public report, it is suggested that the committee should recommend adjustments in medical remuneration only once every three years, remuneration meanwhile remaining unchanged. There would, however, be an exception to this normal arrangement, when any major change (say a movement in the index of more than 10% in either direction) has occurred since the last adjustment was made. In this case an adjustment could be recommended at an intermediate year.

53. The recommendations of the committee would be accepted by both sides. When an adjustment is made in remuneration, it should take effect from a date agreed in advance in relation to the time of the annual review. The Council is advised that an index could be calculated for one year becoming available in the following April, so that the annual review could take place during that summer. It is suggested that, under such circumstances, an adjustment can be made to take effect from April 1st, reflecting conditions in the previous year.

54. The effect of these proposals, as regards timing and under normal conditions, would be to postpone the adjustment in remuneration based on the circumstances of one year to the following April, and then to keep the new level of remuneration unchanged for three further years, save in the exceptional circumstances referred to in para. 52.

55. There are clear advantages to the procedure proposed above. It ensures that ascertainable facts are known. It means that the profession can be certain that its remuneration will be kept under continuous review and that any need for adjustments will be made the subject of a public report. The country as a whole would be spared the kind of dispute which has so bedevilled negotiations in the past.

SUMMARY

56. The Council holds that the existing channels of negotiation are reasonably satisfactory so far as routine matters affecting the terms and conditions of service are concerned.

57. It is clear that such arrangements as exist for settling disputes of major financial importance are quite inadequate, and the Council recommends that medical remuneration should be the subject of an annual review and report by a standing committee appointed by the Prime Minister whose terms of reference and composition should be agreed with the profession. Both the Government and the profession would have the right to make representations to the Standing Committee.

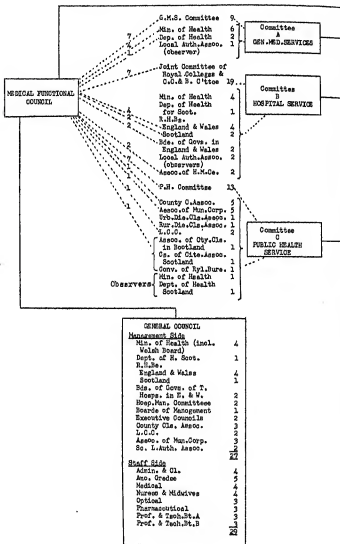
58. Once remuneration has been agreed, it would remain unchanged for a period of three years, except where a substantial change has taken place (10% is recommended), and even then the freeze would operate for one year.

59. It would be agreed that the findings of the standing committee would be accepted by both sides.

60. A procedure of this kind would eliminate the protracted disputes which have been so unfortunate a feature of the past.

61. The Council hopes that this procedure will commend itself to the Commission as a constructive attempt to solve a difficult but vital problem.

APPENDIX A



APPENDIX B**Industrial Courts Act, 1919**

Any trade dispute, as defined by the Act, may be reported to the Minister of Labour by or on behalf of either party. The Minister may, with the consent of both parties, refer the dispute, whether existing or apprehended, to the Industrial Court for settlement.

The term "trade dispute" means "any dispute or difference between employers and workmen, or between workmen and workmen connected with the employment or non-employment, or the terms of the employment or with the conditions of labour of any person."

"Workman" is defined as "any person who has entered into or works under a contract with an employer whether the contract be by way of manual labour, clerical work, or otherwise, be expressed or implied, oral or in writing, and whether it be a contract of service or of apprenticeship or a contract personally to execute any work or labour."

Industrial Disputes Order, 1951

This Order replaced the Conditions of Employment and National Arbitration Order, 1940, which was designed to prevent the stoppage of work during the war through trade disputes and strikes.

The 1951 Order gives the Minister of Labour and National Service power to bring both parties to a dispute to compulsory arbitration when machinery for voluntary settlement has been exhausted. The Industrial Disputes Tribunal is set up under this Order.

Disputes can be reported to the Minister by an organization of employers, by an employer, or by a trade union. A dispute cannot be reported by an individual employee. The report, on behalf of an individual employee, must be made by a trade union. All members of the union employed by that authority would become collectively parties to the dispute.

The term "dispute" does not include a dispute as to the employment or non-employment of any person or as to whether any person should or should not be a member of any trade union but, save as foreshadowed, means any dispute between an employer and workmen in the employment of that employer connected with the terms of the employment or with the condition of labour of any of those workmen.

The term "workman" has the same definition as under the Industrial Courts Act.

From the foregoing it will be seen that the British Medical Association, which is not a trade union, cannot have access to the Industrial Disputes Tribunal. The medical profession, through its negotiating machinery, has, however, on various occasions in the past reported disputes under the Industrial Courts Act.

SECOND SUPPLEMENTARY MEMORANDUM OF EVIDENCE

presented by the British Medical Association to the Royal Commission on Doctors' and Dentists' Remuneration, June 1958

HOSPITAL MEDICAL STAFFS

1. In its preliminary memorandum of evidence and in its oral representations to the Royal Commission the Council emphasized its adherence to a proper implementation of the Spens Reports and the profession's expectation that the Government would honour the promises made to it that remuneration would be based upon the recommendations of those Reports.

2. The preliminary memorandum concentrated upon the broad issues involved.

3. This second supplementary memorandum sets out the detailed recommendations of the Council in respect of each grade in the hospital service and deals with a number of specific points which have a financial bearing upon the recruitment and maintenance of an adequate and efficient hospital medical staff. The position of the consultant has already been referred to at some length in the Council's preliminary memorandum. For this reason the problems of the more junior staff are set out at relatively greater length in this present document. Some of these matters have already been referred to by the Commission itself.

4. The Council's evidence in this field is based upon the submissions of the Central Consultants and Specialists Committee, which, besides being a standing committee of the Council, is, with its Regional Committees, the only representative organization of hospital staffs as a whole. This Committee represents directly consultants and S.H.M.O.s throughout Great Britain and has made provision for special representation of junior medical staffs (which also have a central and regional organization) and of groups of consultants practising in various specialties, e.g., radiology, anaesthetics, etc. The hospital medical staffs in Great Britain number over 20,000, viz.:

Consultants	...	...	...	...	...	7,420
S.H.M.O.s	...	...	...	...	...	2,610
Senior Registrars	...	...	...	...	...	1,176
Registrars	...	...	...	...	...	2,822
J.H.M.O.s	...	...	...	...	...	806
House Officers and Senior House Officers	...	...	...	...	...	5,449
						<hr/> 20,283 <hr/>

The Hospital Service

5. The young doctor, having completed his undergraduate training, normally seven years, served in hospital for a year as a provisionally registered practitioner, and at present a further two years as a doctor in the Armed Forces, finds himself for the first time free to decide upon his future career subject to opportunity and the restrictions of competition. He has already reached an age when his contemporaries in many other walks of life have advanced to a point from which definite career prospects are in sight. At this stage the young doctor is entitled to something more certain. Already the financially barren years of studentship and the almost barren year of pre-registration hospital appointments (as at present paid) have restricted his total life earnings and the amount of his pension.

6. For the doctor who chooses a career in hospital practice training and preparation for a consultant post are long and arduous, and the outcome in any circumstances unpredictable. Competition for consultant posts is exceedingly keen, and the uncertainty of final achievement must be prominent in the mind of the young hospital doctor during his registrarship, senior registrarship, and, even after, while, fully trained, he awaits a consultant appointment. And if he is one of those who find himself approaching 40 years of age without obtaining a consultant post, he must seriously consider turning to some other walk of medical life. This will almost

certainly mean a fresh approach to the future, with the prospect of a less remunerative career than he had planned. This doctor has had no chance of saving against such a contingency whilst remunerated as he is at present, and his critical decision is most likely to coincide with the time when family expenses are entering their heaviest and most crippling phase.

7. The Council wishes to emphasize that, although the young hospital doctor undoubtedly holds a training post, he is in fact also providing an important and essential service to the hospital and the community.

8. The remuneration of all hospital doctors should be related to the responsibilities of the post and the essential contribution they make to the work of the hospital. The training they receive whilst holding these posts is incidental to their primary function, and the responsibility and qualifications of senior registrars and registrars make it particularly necessary to ensure that they are suitably paid.

9. It is generally accepted that, in order to obtain the higher qualifications essential for a consultant post, an expensive course of study must be undertaken at some period, involving for many a period of no employment. Also the transfer from one appointment to another is not a matter of immediate succession. Appointments fall vacant at varying times, and it is the common experience of young doctors in the hospital service that they have periods of no employment between posts. Their hospital appointments are of varying tenure, but never permanent, and they have to be prepared to move about the country whenever further posts become available.

10. During this formative period of his life, the young hospital doctor, who may have a family to support, can rarely establish himself in a settled home. It is, of course, important that he should acquire as broad a training and experience as possible, but if he has a family this constant movement from post to post involves him in heavy expenses, including removal expenses which are met by the employing authority only in certain limited circumstances. In addition, he must be prepared to meet course and examination fees. It would be contrary to the ultimate interest of the hospital service, and therefore of the community, for the consultant of the future to restrict his training to only one hospital. It is wrong that he should be out of pocket during this process. The necessity for these expenses should therefore be recognized, and they should be reimbursed as is suggested later in this memorandum.

11. The question of a family allowance payable to all grades of hospital medical staff up to and including senior registrars has been considered, and the Council believes that this would be one way in which the problems of hospital junior medical staff might be eased. Such an allowance is payable to members of the Armed Forces and to members of university staffs, many of whom are in a position comparable to that of hospital junior medical staff.

Hospital Medical Staffing

12. In the view of the Council the establishment of an adequate consultant service, and satisfactory salary scales for all grades of medical staff, are the two pressing problems in the hospital service at the present time. It is believed that the former would in a right manner solve many of the problems of hospital junior staffing, and pave the way for a satisfactory staffing structure. During the past few years unsuccessful attempts have been made to relate the numbers of senior registrars to the number of consultant vacancies, but this has been done without regard to the needs of the service and without any central planning as to the number of consultants required to provide an adequate consultant service.

13. It is clear to the Council that a drastic overhaul of the structure of medical staffing of hospitals is long overdue. What is needed in the hospital service is first an early review of establishments and staffing structure, and second the application of rates of remuneration which conform to the recommendations of the Spens Report. The first is under discussion with the Ministry of Health, and is largely outside the terms of reference of the Commission. The second is the subject of recommendations which appear in a later section of this memorandum.

14. It is well known that many hospitals are experiencing difficulty in obtaining junior staff, and the situation would be even more serious but for the availability of overseas graduates. The institution of just scales of remuneration with reasonable

career prospects would do much to prevent the deflection from hospital work of men who could well fill the junior posts for a little longer and not feel bound to look for other openings at the earliest opportunity. At present, the realization that greater rewards are available elsewhere at an earlier age has of itself created a junior staffing problem in hospitals. What is to be wondered at is that so many stay to become senior registrars and there remain. They are grossly underpaid and many are in serious financial difficulties.

Emigration

15. The Council is in little doubt that the possibility of emigration is much more prominent than before in the minds of medical students and the newly qualified. This is believed to arise from the uncertain and unattractive prospects of a career in the N.H.S. Hospital Service. The recent survey of opinion among students in Edinburgh University which is described in the Memorandum of Evidence of the Joint Consultants Committee would seem to support this view. The volume of enquiries reaching the Association about prospects overseas has greatly increased, and it is known that a number of able and promising doctors have emigrated, as indeed have some doctors already well established. The Council believes it right that emigration should take its proper quota of doctors trained in this country, but deplores the fact that the idea of leaving the country is becoming uppermost in the minds of so many of our young doctors.

CONSULTANTS

The Present Staffing Structure

16. The ultimate responsibility for the care and treatment of patients in general and specialist hospitals must be in the hands of practitioners of consultant status. The Council is opposed to the introduction of a sub-consultant grade or to any other method of diluting the quality or the remuneration of senior medical staff.

17. Consultants are appointed on either a whole-time or part-time basis. Approximately three-quarters are at present employed in a part-time capacity with the right to engage in private practice—the majority from choice, though there are cases where the alternative of a whole-time appointment is not available.

18. Private practice, however, is known to have decreased considerably since the start of the National Health Service, and, with the exception of a small number of consultants who were already well established, the financial rewards accruing to the part-time consultant from this source are comparatively small. In the case of many men in their earlier years such earnings are virtually non-existent. The profession as a whole attaches the greatest importance to the freedom to undertake private practice. Any suggestion that the hospital consultant service should be run on a purely whole-time basis arises from the personal predilections of a small minority who themselves are personally undesirous of taking part in private practice of any kind. These personal opinions are respected by others, and whole-time posts are available for them, but the Council has heard of no arguments to suggest that the value of the Hospital Service would be enhanced by the abolition of part-time contracts.

19. On the contrary, it is the view of the Council that even though the rewards to many are small, the continuance of private practice is of benefit to the community. There is professional freedom which many find essential for the maintenance of a high standard of work. Further, the Council contends that the preservation of private practice is essential to the proper development of medicine in this country.

The Whole-time Consultant

20. There are a number of reasons why some consultants prefer whole-time employment, but the underlying influence is often that they feel that they can do their best work under these conditions. Geographical and other considerations, as, for instance, the long-standing tradition of whole-time employment in certain specialties, also play their part.

21. The whole-time consultant, in common with his part-time colleague, incurs certain unavoidable expenses in connection with his work, and the failure of the Terms and Conditions of Service to make appropriate financial arrangements for this is one of the major injustices suffered by whole-time consultants in the Health Service. It is rarely possible for a doctor of consultant standing to perform his duties without possessing a car and yet the mileage payments that he receives from the Hospital Board for the use of his car in the Board's service can only rarely be such that he is not in fact providing a car for the Board service at considerable net cost to himself. If he lives out he must have a telephone, but he cannot claim the rental charge from the Board. Yet, although he can claim reimbursement for the calls he makes in the Board's service, it is equally important that he should have a telephone so that the hospital can call him. Indeed the recent changes in telephone rentals and charges for calls are to his even greater disadvantage and, incidentally, will reduce the cost to the Board.

22. It is also essential that all consultants, whether whole-time or part-time, should keep abreast of modern trends in their specialties.

23. In para. 16 of the Consultant Spens Report reference is made to this matter of expenses, which include such items as car and telephone, the cost of books and periodicals, subscriptions to professional societies, preparation of scientific papers and attendance at both professional meetings in this country and overseas, all of which are the normal and necessary accompaniments of any doctor's work. The Spens Committee recommended that all specialists engaged either whole-time or part-time should be paid in addition to their remuneration any sums representing expenses necessarily and reasonably incurred in the course of their work. It suggested that such expenses might either be refunded after they had been incurred, or alternatively that an appropriate allowance might be attached to various appointments. Efforts to obtain a satisfactory implementation of these recommendations have so far proved unsuccessful, and the Terms of Service in this respect are in direct contradiction to the terms of the Spens Report, the acceptance of which by the Government was a direct major factor in the decision of consultants to enter the Health Service.

24. The Council holds the view that it is a reasonable obligation upon hospital employing authorities to defray the expenses properly incurred by their medical staffs in discharging the duties of their appointments. It therefore urges that the obvious intention of the Spens Committee's recommendations should be fully implemented.

25. It must also be pointed out that the Spens Committee referred to the income-tax aspect of this problem by presuming that the Inland Revenue Authorities would be prepared to consider favourably, as legitimate allowances for income-tax purposes, any expenditure by one of its medical staff approved by the hospital authority. Whole-time consultants receive no income-tax allowances for these expenses at the present time.* If the recommendation of the Royal Commission on Taxation of Profits and Incomes dealing with the rule governing expenses under Schedule B assessments was adopted, the whole-time consultant would undoubtedly be able to claim tax relief in respect of many of the expenses in question. This would not meet the situation fully, but would at least alleviate the burden to some extent.

The Part-time Consultant

26. Although a consultant with a part-time contract is in a better position in regard to income-tax allowances, he receives less remuneration and thus a lower pension for his hospital work and has no certain prospect of making up the balance of his professional income from private practice.

27. It is important for a proper appreciation of the position of the part-time consultant to understand that, however few his sessions, HE STILL BEARS A CONTINUOUS RESPONSIBILITY for his patients in the hospital.

* Since the preparation of this memorandum, the Chancellor of the Exchequer has introduced legislation to provide some relief from tax under Schedule E in respect of subscriptions to professional organizations.

28. Part-time contracts are determined on an assessment of the average amount of time involved in fulfilling the duties of an appointment. In addition the part-time consultant has a continuing liability beyond his sessional time to attend the hospital in an emergency or at any time required by the needs of his patients, and other liabilities in the Service such as committee work. Many consultants (both whole-time and part-time) give much time to work on advisory and administrative committees associated with the running of hospitals, and the services and advice given by hospital medical staff on these committees are of inestimable value to the hospital service. In effect, therefore, a large number of consultants give a great deal of time to the running of the hospital, and this is yet another illustration of the fact that the consultant, whether part-time or whole-time, gives a continuing service to the hospital which cannot be defined in hours or notional half-days. In order to cover these continuing or extraneous duties, the Spens Committee recommended and the terms provide for a weighting factor which is used in calculating the proportion of the whole-time salary scale which should be paid to the part-time consultant. In 1954, when the salaries of hospital medical staff were adjusted, the Staff Side was obliged to accept a reduction of this weighting factor, from $1\frac{1}{2}$ sessions at the maximum to $\frac{1}{2}$ of a session, despite the fact that since the commencement of the service the consultant's extraneous duties had considerably increased. The Council contends that there is no justification for this reduction and that the original position should be restored.

The Consultant with a Few Sessions

29. Some consultants' appointments are for only a few sessions, and the holder of the appointment is consequently remunerated at a low rate, which does not provide a satisfactory competence. In densely populated areas it is sometimes possible to combine appointments so that an eight- or nine-session appointment is built up, or payment for teaching duties or a research appointment may have the same effect. But in some specialties and in some areas the demand for the services of a consultant, while still essential, is nevertheless related to a small quantity of work and it is not possible to make combined appointments. In such circumstances there would seem to be a clear need for a more liberal application of the provision already made for a special rate of remuneration to make up for the impossibility of deriving an adequate living in a post which must be filled in the interests of the Service. (See para. 5 (c) of the Terms and Conditions of Service and para. 27 of the Ministry Circular RHB 49/85. See Appendix I.)

30. Thus it will be seen that whole-time consultants are harshly treated in the matter of expenses and income-tax law and some part-timers have insufficient sessions and are unable to make up the balance by private practice. Both are seriously underpaid having regard to the recommendations of the Consultant Spens Report.

Special Distinction Awards

31. The Council is in favour of the remuneration of a proportion of consultants by the method of special distinction awards. It regards this as an appropriate incentive to younger men to enter the profession and the Hospital Service. It is satisfied with the method of administration of the awards.

32. The Council, however, wishes to point out that the Spens recommendations regarding distinction awards have never been fully implemented inasmuch as the three awards recommended by Spens in terms of the 1939 values of money, namely, £2,500, £1,500, and £500, have never been adjusted to current money values. Moreover, as a result of the 1954 award, the two higher awards were, in effect, reduced because at that time consultants with these awards suffered a reduction in their basic salary of £300 and £200 respectively. This decrease will of course be reflected ultimately in the consultant's pension.

33. In this context the Council reminds the Royal Commission that the special distinction award is awarded to part-time consultants not at the full rate but at a rate which bears the same relation to the figures quoted as his part-time hospital salary does to the whole-time salary.

34. It is proper and desirable that there should be within the reach of a number of consultants rewards commensurate with the earnings of outstanding men in other fields, both in professions and in business. This was one of the purposes of the special distinction awards, and the Council believes that they should be brought much more closely in line with present-day values of money. Distinction awards should continue to be available to 34 per cent of the total establishment of consultants. The Council further believes that in all fairness the existing distinction awards should be increased to the same extent as the basic salary of the consultant at its maximum point. The figure now claimed at the maximum of the basic scale is approximately £4,000, which is an increase of 60 per cent over the 1939 figure of £2,500 recommended by the Spens Committee. The Council therefore recommends that each of the three distinction awards should be increased by 60 per cent, that is to say, to £4,000, £2,400, and £800 respectively.

Domiciliary Consultations

35. The Domiciliary Consultation Scheme provides the family doctor with the opportunity of obtaining a consultant opinion in the home for any patient unable to attend hospital. The Council considers this to be a highly important and beneficial feature of the N.H.S.

36. The payment offered to a consultant for this service has since the beginning of the N.H.S. remained as follows:

Fee for consultation, 4 guineas, with an additional fee of (1) 2 guineas where any operative procedure other than obstetric is undertaken or where the officer uses his own electrocardiograph or portable X-ray apparatus; (2) 4 guineas for an obstetric operation; the additional fee of 2 guineas or 4 guineas to be payable only once in respect of each patient for the current illness. An additional fee of 1 guinea is also payable for a journey to a place over 20 and up to 40 road miles distant, 2 guineas for a journey to a place over 40 and up to 60 road miles distant, and so on with an additional guinea for every 20 miles. The maximum remuneration (excluding travelling and subsistence allowances, additional mileage payments, and fees for the use of the consultant's own apparatus) is fixed at 200 guineas in any quarter or 800 guineas in any year, at the consultant's choice.

In November, 1955, it was agreed in Committee B of the Medical Whitley Council that whole-time consultants should be entitled to domiciliary consultation fees for all visits after the first eight in any one quarter.

37. There is a quarterly or annual "ceiling" on payment for domiciliary consultations. Nevertheless, the consultant who has contracted to undertake domiciliary consultations is still liable to be called in consultation by a general practitioner even though he may have completed the maximum number for which payment is made.

38. The first eight consultations made by a whole-time consultant in each quarter are unpaid. This restriction undoubtedly plays its part in inhibiting the general practitioner from asking a whole-time consultant to perform a task for which he will not be paid, and the result is that he calls in a part-time consultant for the domiciliary consultation. The waiving of this unfair restriction would therefore lead to no greater cost to the Hospital Service. Moreover, it is contrary to the recommendation of the Spens Committee.

39. The Council points out that the fee for this service has remained static since the inception of the N.H.S., and is of the opinion that the fee and other payments concerned with the domiciliary consultation scheme should be increased by 60 per cent, i.e., in the same manner and for the same reasons explained in the case of special distinction awards.

40. The Council also recommends:

- (i) That the additional fee payable for distance be £1 ls. in respect of journeys to a place over 10 and up to 20 miles distant and £1 ls. in respect of each further distance of 10 miles.

- (ii) That the maximum remuneration (excluding travelling and subsistence allowances, additional mileage payments and fees for the use of the consultant's own apparatus) be fixed at 320 guineas in each quarter or 1,280 guineas in any year at the consultant's choice.
- (iii) That the fees be payable to all consultants and S.H.M.O.s agreeing to undertake domiciliary consultations, irrespective of whether their contracts are for whole-time or part-time service.

Superannuation

41. The hospital doctor with a whole-time contract is entitled to a pension assessed at 1/80 of his average salary over the last three years for each contributory year of service up to a maximum of 45 years.

42. A consultant is required to retire at 65, and he is therefore unable (except in the case of those designated as "mental health officers") to earn the maximum pension (45/80) because he cannot complete 45 years' service. A part-time consultant under contract for not less than nine notional half-days may apply to the Minister to have his pension assessed by the method referred to in the preceding paragraph, but the application, if granted, applies only to the assessment of pension in respect of subsequent earnings. If he does not so apply or if he is engaged for less than nine notional half-days, his pension will be assessed as for general practitioners at the rate of 1½ per cent of his total earnings over the period of service (with a maximum of 45 years).

43. The Council recommends that the maximum part-time consultant should be allowed to opt for either method of assessing his pension at the end of his service. This recommendation should also be applied to senior hospital medical officers, who are in the same position so far as superannuation is concerned.

GENERAL CONCLUSIONS

44. The preceding paragraphs outline some of the difficulties which have arisen in the hospital service, stress the need for an early review of hospital establishments and staffing structure, and emphasize that much of the present dissatisfaction in the Hospital Service is due to the fact that the remuneration of all grades has never been properly related to the recommendations of the Consultant Spens Report and is quite inconsistent with changes in the value of money which have taken place since the inception of the Service.

45. At best the basic salary scale of consultants in the Hospital Service can only be regarded as representing 1951 values of money (apart from the 5 per cent interim adjustment), and a substantial increase is long overdue.

46. Moreover those in receipt of special distinction awards, an integral and pensionable part of total remuneration, have received no increase in that part of their remuneration since the inception of the Service nearly 10 years ago.

47. In conformity with the Council's general claim the necessary percentage to be added to the basic incremental scale for consultants is at least 29 per cent. This amount would offset the fall in the value of money since 1951, but for reasons set out in the Council's preliminary memorandum of evidence it still does not fully relate consultants' remuneration to the changes in the value of money which have, in fact, occurred between 1939 and 1951.

48. So far as distinction awards and domiciliary consultation fees are concerned, it is claimed that these should be increased by 60 per cent for the reasons stated in paras. 31-40.

49. Further, it is claimed that both distinction awards and domiciliary fees should in future be regarded as "remuneration" when any future adjustment is indicated. In addition, the restriction on the first eight consultations for whole-time consultants should be abolished.

50. The Council recommends that the remuneration of consultants in the Hospital Service should be on the following scales (on a whole-time basis):

		Consultant—basic			
20 per cent of consultants to receive in addition		£800	£2,700 × £162	10s.—£4,000	
10	"	"	£2,400	£3,500—£4,800	
4	"	"	£4,000	£5,100—£6,400	
				£6,700—£8,000	

SENIOR HOSPITAL MEDICAL OFFICERS

51. The senior hospital medical officer grade, which now forms over one-quarter of the senior grades of the National Health Service, was not envisaged by the Consultant Spens Committee. It was devised as a transitional grade for certain local authority medical officers and for a few medical men of limited experience. As such it was accepted by the profession, but on the understanding that it was a temporary grade which would disappear as the holders of these posts retired. The grade, however, included within it many members of the senior medical staffs of hospitals, both general and specialist. With the adoption of the Ministry's circular R.H.B. 50/96 expansion of the grade took place until the present number of more than 2,600 S.H.M.O.s was reached (latest figure available June, 1956). There is no doubt that the increase continues.

52. The various groups of medical men who in the above manner have been included within the grade may in the main be conveniently summarized as follows:

- Doctors employed before 1948 by local authorities.
- A number of general practitioners who were working in hospitals in 1948, especially in the provinces and country districts, where it was customary for suitably qualified or experienced doctors to combine general practice with the practice of a specialty in the local hospital. A number of these have subsequently given up general practice and are now engaged solely in their specialty.
- Senior hospital medical officers appointed following the adoption of the circular R.H.B. 50/96.

53. Prior to the offer of permanent contracts in the National Health Service, transferred officers were graded by professional committees, and many who had previously been and were still carrying out medical work of full clinical responsibility were graded as S.H.M.O.s. The decision of these professional committees caused great dissatisfaction and hardship, and as a result individual appeals against grading were allowed and some were successful. There was a further review of grading in 1951-2, but no regrading has taken place since then. Such S.H.M.O.s have now had extensive experience in their specialties, and an impartial review of their grading, based on experience and the quality of their work, might now reasonably be expected to result in upgrading of many S.H.M.O.s in posts where consultant work is being done to consultant status and salary. No criteria were laid down for the guidance of grading committees, and in consequence both the original gradings and those held subsequently varied from locality to locality and specialty to specialty. Consequently, in some cases an individual has been graded and paid as a consultant in one hospital region and graded and paid as an S.H.M.O. in another.

54. It may be argued that certain S.H.M.O.s who were transferred officers (Group (a)) do not possess higher qualifications, but the same is true of some consultants of similar age, because in the past promotion in certain types of hospitals depended more on years of experience than on higher degrees and diplomas. To regard such men, experienced and efficient in their work for many years, as of sub-consultant grade because they did not obtain a higher qualification or diploma would, in the Council's view, be unfair.

N.B.—Throughout this document figures relating to both the profession's claim and present levels of remuneration ignore the interim payments made by the Government last year and require modification to that extent.

55. Other S.H.M.O.s, especially those in Group (c), are of a high academic standard and training, but were compelled to apply for S.H.M.O. posts for economic reasons.

56. The Ministry circular RHB 50/96 (Appendix 11), introduced in 1950, defined the type of posts in the medical establishments of hospitals in which appointments might be made in the S.H.M.O. grade and also limited the number of specialities in which the grade was permitted. Unfortunately, the circular gave little or no indication of the clinical or academic standards required, and no ratio was laid down between the numbers of consultants and S.H.M.O.s. As a result, there has been exploitation and expansion of the grade to such an extent that it can now be said that clinically, academically, and administratively the duties and responsibilities of many S.H.M.O.s are indistinguishable from those of many consultants, and their appointments have been at variance with the stated objects of the RHB 50/96.

57. The S.H.M.O. grade has acquired an unwarranted stigma of professional inferiority. Many S.H.M.O.s hold the appropriate higher qualifications and have undergone training as senior registrars, but have been forced to take S.H.M.O. posts because of the lack of consultant vacancies. In effect they are still in competition for consultant posts with senior registrars, but inevitably with increasing age their prospects of promotion grow less. Thus the S.H.M.O. grade has become for the large majority a career grade, although one with poor prospects. The unfortunate holder of one of these posts finds it more difficult as the years pass to obtain a consultant appointment or to enter general practice, and he is faced with a permanency in a sub-consultant grade, with its attendant frustration and intense dissatisfaction. The S.H.M.O.s who attain consultant status are usually over 40 years of age, with the result that their life earnings as consultants have been greatly diminished. It is also the case that despite the "no detriment" clause in the Terms of Service some S.H.M.O.s who are transferred officers, and were previously paid on a sessional or item of service basis, have suffered a diminution of income since the National Health Service came into being. In addition, certain S.H.M.O.s have had to accept full-time employment in the National Health Service, and private practice is therefore debarred. For others, private practice has suffered because it is known that they have not been graded as consultants.

58. The disabilities in relation to proper allowances for essential expenses referred to in paragraphs 21-25 apply with equal force to S.H.M.O.s.

59. The increase in the number of S.H.M.O. appointments in the permitted specialities since 1950 is in the order of 30 per cent, compared with 17 per cent in that of consultants. As a result, in chest diseases there are in two areas 7 S.H.M.O.s and 1 consultant (while 3 S.H.M.O.s to 1 consultant is common); in 1953 the number of consultants in the specialty was 340 and the number of S.H.M.O.s 334; in 1954 the figures were 344 consultants and 358 S.H.M.O.s; in 1955, 346 consultants and 415 S.H.M.O.s; in 1956, 347 consultants and 430 S.H.M.O.s; and on June 30, 1957, there were 446 S.H.M.O.s in the specialty and only 347 consultants. The expansion, therefore, of the consultant establishment since 1953 has been 7, and that of the S.H.M.O. establishment 112.

60. The regulations regarding age of appointment is the same for consultants and S.H.M.O.s, i.e., both should have attained the age of 32 years—although of recent years appointment is often at a much later age.

61. Assuming appointment at age 32, a consultant on the basic scale earns £33,225 more than his S.H.M.O. colleague by the time he is 65 years of age. (See Appendix III.)

62. The annual increment of the S.H.M.O., viz. £50, is the lowest of any medical grade in the Hospital Service, and is £75 less than the consultant increment. Regional Boards have been allowed discretion in the granting of starting increments up to four, depending on age, qualifications, and experience, but there is no appeal against the Board's decision, and experience has shown that more and more appointments are being made at the commencing salary of the S.H.M.O. grade whatever the applicant's age.

63. Relative to the basic earnings of the full-time consultant, the ratio of the S.H.M.O. salary falls from 75 per cent at the minimum of the salary scale to 65 per

cent at the maximum. An S.H.M.O. therefore suffers with age, as far as his earnings are concerned, relative to the consultant, and the effect of this on superannuation is of great importance.

64. The salary of a newly appointed consultant is now £75 greater than that of a practitioner of ten years' experience in the S.H.M.O. grade. Prior to the 1954 award the maximum of the S.H.M.O. scale exceeded the minimum of the consultant scale by £50. The 1954 award, however, changed this position, with the result that the S.H.M.O.'s maximum salary became £150 less than the minimum of the consultant's scale. As a result a claim was lodged for an increase of £200 to restore the pay differential to its former level. The claim was referred to the Industrial Court, which awarded an increase of £75 per annum. The differential has thus never been fully restored and the present S.H.M.O. scale is £1,575-£2,025.

65. Although many S.H.M.O.s are undertaking consultant duties, and themselves have qualifications and experience indistinguishable from those of consultants, because they are not graded as consultants they are not eligible for merit awards.

66. It has already been pointed out that clinically, academically, and administratively there is no clear line of demarcation between many S.H.M.O.s and consultants. For this reason the Council wishes to emphasize that there is an urgent need for a national review not only of hospital establishments, but also of the present grading of individual S.H.M.O.s, including the type of work now being undertaken. Long term, the Council believes that the abolition of the grade and a proper redistribution of its members is the only means by which the present anomalies can be remedied and justice afforded to the holders of these posts. *Meanwhile, the Council recommends that the salary of the S.H.M.O. grade should be at least 80 per cent of that of the full-time consultant on the basic scale.* This would, at least, be a more realistic evaluation of the work which S.H.M.O.s are doing in the Health Service.

67. On the basis of the Council's general claim and in the light of the differential referred to above, it is therefore recommended that the salary attached to the S.H.M.O. grade (during such time as it continues to exist) should be, on the basis of 80 per cent of the salary scale recommended for consultants in paragraph 50—£2,160 × £130-£3,200.

JUNIOR HOSPITAL STAFF

68. The Council is anxious that the Commission should be left in no doubt as to the importance which the profession attaches to the institution of adequate scales of remuneration for all grades of junior hospital staffs.

69. In forwarding this section of its second supplementary memorandum of evidence the Council wishes to acknowledge the very great help it has received both from the Junior Staffs Group of the Association in England and Wales and the Hospital Junior Staffs Group Council in Scotland. Both these bodies submitted lengthy memoranda of evidence to the Council, and, although the views expressed have been integrated and presented as one section to this memorandum, they are in the main set out below in the form in which they were originally presented. The Council wishes to emphasize that both bodies have an active peripheral organization through which there is representation of the junior staffs of every hospital in the country.

70. In this way, the Council speaks with authority on behalf of this important section of the profession, which comprises:

House officer—pre- and post-registration	...	...	...	...	3,267
Senior house officer	...	...	...	...	2,182
Junior hospital medical officer	...	...	...	...	806
Registrar	...	...	...	...	2,822
Senior registrar (not including 93 honorary and 26 part-time senior registrars)					
In first 3 years of training plan	...	...	...	...	828
In final year of training plan	...	...	...	...	153
Fully trained (5-9 years in senior registrar grade already)	...	...	...	...	195
					1,176
					<hr/> 10,253

71. The Council wishes to make it clear that its general claim, as developed in its preliminary memorandum of evidence, is fully applicable to all the above grades and that the purpose of this further evidence is to deal with other factors which cause serious financial hardship to hospital junior staffs for which relief or compensation is urgently needed, such as prolonged insecurity and poor promotion prospects.

Present Conditions

72. At the present time, hospital junior staffs consist of individuals aged between 23 and something over 40. A substantial number are between 35 and 40.

73. Besides a full day, most of them undertake a large amount of night and week-end work. This is not compensated by remission of duties, nor is there any day and night rota system or a fixed working week of so many hours. Much of the night work is concerned with the reception, diagnosis, and treatment of emergency cases, and is of a most responsible kind. Within this already full schedule, those with further ambitions have to find time to study for higher professional examinations and to keep abreast of the large volume of current literature, carry out original work, and write articles for publication. In teaching hospitals, registrars and senior registrars also provide a substantial proportion of the daily clinical teaching. In all this their way of life is the one traditionally accepted as normal, which every generation of junior hospital doctors must follow in turn.

74. Nevertheless, it must be remembered that, although these are young men aspiring to a consultant career, they are often married with family commitments and are subsisting on a salary originally intended for a much more junior person, and their standard of living is consequently modest. A selection of representative budgets illustrating the financial difficulties of junior hospital medical staff are set out in Appendix IV.

75. As the years pass they suffer increasing anxiety about the future, for although there may be many posts available in the more junior grades, the real trainee consultant, the registrar or senior registrar, is faced with much uncertainty. Their posts are subject to annual review, and after four years in the senior registrar grade, by which time they are usually in the mid-thirties, fully trained, and with family commitments, they must depend on further annual extensions of their appointment for a livelihood. If the extension is not granted they can try to find another senior registrar post elsewhere, knowing that in another area they may be unknown, with greatly reduced prospects of a consultant post. Such a move, being technically voluntary, must, of course, be undertaken at their own expense. In former times, if prospects of a permanent hospital appointment seemed remote or slender, there were other secure openings offering scope for consultant talent—the Indian Medical Service or a good general practice with access to hospital beds, for example. Since the Government is now a monopoly employer of specialist hospital doctors, the only other courses open are to emigrate, go into industry, or attempt to start a new career in another branch of medicine with all its attendant difficulties. It is, for example, extremely difficult—indeed, virtually impossible—for men with only hospital experience to obtain a vacancy in general practice.

Causes of Dissatisfaction

76. The present grade structure of the Hospital Service had not been established when the Spens Committee reported. The proposals were therefore related to hypothetical grades defined by age and time after registration, as follows:

- (a) Grade III: posts obtained normally not less than one year after registration and held normally for one year only (e.g., senior house officer, resident medical officer, etc.).
- (b) Grade II: posts obtained normally not less than two years after registration and held normally for two years at the ages of 26 and 27 (e.g., assistant, junior registrar, etc.).
- (c) Grade I: posts obtained normally not less than four years after registration and held normally for three years at the ages of 28, 29, and 30 (e.g., first assistant, chief assistant, senior registrar, etc.).

(Spens Report, Cmd. 7420. May 1948, pp. 8-9.)

77. Elsewhere the Spens Report gives 23-24 as the normal age of qualification (page 5) and allows for the possibility of a fourth year in Grade I (page 9).

The present titles of these grades in the N.H.S. are:

Grade III—Senior house officer

Grade II—Registrar

Grade I—Senior registrar

The salaries proposed in 1939 values of money were:

Grade III—£600 (fixed)

Grade II—£700-£800 in one increment

Grade I—£900-£1,200 in three increments.

Delayed Promotion and Total Life Earnings

78. In Scotland an attempt has been made to discover as precisely as possible the promotion prospects of senior registrars by comparing the number of senior registrars in training with the number of consultant vacancies likely to occur in future years on the basis of retirement of consultants at the age of 65. The detailed tables set out in Appendix V have been prepared from figures supplied to the Association by the Department of Health for Scotland giving the year of birth of all consultants and senior registrars in Scotland as on December 31, 1956. No allowance has been made for the occurrence of vacancies due to causes other than retirement. The figures have been broken down to show the situation in each region and in each specialty as well as in Scotland as a whole.

79. From Table I it will be seen that there are at present 250 senior registrars in Scotland: 41 of them have already held their present posts for more than four years, the initial duration of the appointment, and many others have held previous appointments in this grade. Their average age of 35 is already three to five years more than the Consultant Spens Committee envisaged. During the next five years there will only be 69 vacancies for these 250 candidates, and in fact not until 1969 will the necessary 250 vacancies have occurred. Senior registrars' contracts extend for four years in the first instance and there is no guarantee that they would be allowed to retain their posts for as long as the twelve years. The foregoing figures are based on the premise that all the vacant consultant posts would be filled by senior registrars, but Table VI shows that only 68 (i.e. 38 per cent) of the 180 posts which became available in Scotland during the last three years were so filled. The remaining 62 per cent were filled by consultants, university staff, S.H.M.O.s, etc.

80. Thus, although 69 consultant retirement vacancies are anticipated in the next five years, previous experience indicates that only 26 of these posts (38 per cent) will be filled by senior registrars. *Put in another way, this means that, of the present 250 senior registrars, only 5 are likely to become consultants each year during the next five years.* The position might be less gloomy if Scotland exported an abundance of specialists. But such evidence as is available suggests that this is no longer the case.

81. A study of the Tables thus shows that the promotion prospects of those already trained and in training are so very bad that, with the possibilities of employment in the Services, the Colonies, and the Dominions already reduced, immediate action is required to rectify the grave position in which these doctors find themselves. Having applied in good faith for advertised appointments in the training grade of the Hospital Service, they expected to have a reasonable chance of becoming consultants, and it is now quite obvious that they do not have this—either now or in the foreseeable future. Their difficulties are increased because compulsory full-time contracts have made alternative training impossible. There is no reason to believe that they are any less able than those who became consultants during the build-up of the Hospital Service in and after 1948. Those responsible for the administration of the Hospital Service have appointed and trained a number of senior registrars which is grossly in excess of that required to fill the present inadequate number of consultant vacancies. It is of interest and importance to note that the situation will change completely during the period 1977-81, when 243 consultant vacancies will occur, as compared with the 69 in 1957-61 period. Clearly,

long-term planning is needed to ensure that approximately the right number of senior registrars is being trained at any one time. This number will vary considerably from time to time and should be related to the number of consultant vacancies likely to arise. It is not suggested that all senior registrars should automatically become consultants, since a few may well be unsuitable, but it is suggested that the authorities should accept the responsibility for adjusting the number in training to anticipated requirements so that prospects of promotion are at least reasonable.

82. There is in addition a still larger number of registrars—281 in 1955—employed in the Hospital Service in Scotland. This group, who should normally hold their appointments for a period of two years, have promotion problems of their own. Though the grade is no longer necessarily regarded as a training grade, most registrars aim at a career in the Hospital Service. With the possible exception of general medicine, it is hard to see how any doctor who has already served as a house officer for six months can spend two years doing special work in, say, orthopaedics, radiology, or dermatology and not be regarded as "in training." Not only do the registrars outnumber senior registrars, but normally they should hold their appointments for only half as long. Furthermore, the bottle neck in promotion for senior registrars has inevitably resulted in considerable delay in senior appointments becoming available for them. Many registrars have been in this grade for much longer than two years (Table VII), and many others have left the Hospital Service in despair of obtaining a higher post on the training establishment.

83. The end result has been a steady falling-off in number and calibre of applicants for registrar appointments, at first in peripheral and more recently in teaching hospitals. This will result eventually in a deterioration in the standard of senior staff because many young men who are excellent potential consultant material regard the chance of success as unreasonably small and are unwilling to face the prospect of greatly reduced total life earnings which face them on entering the Hospital Service to-day. The number available for selection for promotion in senior registrar rank is correspondingly reduced, which again potentially affects the calibre of the future consultant staff.

84. This picture of the position in Scotland is similar to the pattern which has developed in Great Britain as a whole.

15. For example, the following table shows the number of consultants in the main branches of hospital practice in the United Kingdom who may be expected to retire between 1956-60, the number of sessions thereby made available, and from the number of maximum part-time consultant livelihoods; also the number of registrars and thus the average tenure to be expected in the senior registrar grades:

TABLE A

	No. of Cons. Born Before 1896	No. of Sessions Held	No. of Maximum Part-time Livelihoods	Average Annual Incidence of Vacancies	No. of S.R.s	Average Stay in S.R. Grade
Medicine	95	541	60	15	204	13½
Surgery	111	719	80	20	211	10½
Obstetrics and gynaecology	44	305	34	8½	101	12

Notes.—(1) Column 1 contains individuals over 65 years of age. Many of these have been allowed to serve 10 years in the N.H.S. and will retire in 1958. This has raised the figure in columns 1, 2, 3, 4, and lowers the figure in column 6, although it is, of course, a non-recurrent phenomenon.

(2) Column 3 shows the number of maximum part-time livings which the expected retirements would yield. In fact some of the vacancies will contribute to full-time (11 sessions) appointments, so that the true number of possible promotions is less than column 3 shows.

(3) In addition to the senior registrars in column 5, other competitors for posts include members of university departments and S.H.M.O.s.

(4) These factors are to some extent offset by consultant vacancies created by premature death or retirement.

86. No figures are available to show the ages of the present holders of registrar posts. It is obvious that the average stay in the grade by candidates destined for promotion to the senior registrar grade is much lengthened by the slowness with which vacancies arise by the elevation of senior registrars to consultant posts.

87. This conclusion is borne out by information obtained in respect of one region about the age of new appointees to the senior registrar and consultant grades in the major specialties during the past year. This shows that five men newly appointed to consultant posts in medicine and surgery were either 37 or 38 years of age.

88. In the same period the age of senior registrars appointed in these specialties varied between 32 and 40. Comparable figures for the registrar grade are not available, but ages of new appointees in medicine and surgery varied from 26-37 (the majority 32-34).

89. Disregarding National Service there is now an average delay of six years—two extra years as registrar and four as senior registrar beyond the normal term. These posts yield a total income of £7,530 and reduce the number of years at the maximum consultant salary (£3,100) by six, a loss of total life earnings of £11,070 at 1954 rates. The financial results of delayed promotion are illustrated in Appendix VI.

Salary Scales

90. In the Council's view, junior hospital staff are underpaid both absolutely and in relation to the senior staff. Four factors have contributed to this situation:

- (i) The Consultant Spens Committee envisaged that the age of consultants when first appointed would normally be 32, and the present salary scales of all hospital staff were worked out and agreed on this assumption. As the average age of senior registrars is now 35 their total life earnings are correspondingly considerably reduced by the present state of affairs.
- (ii) The present salary scales were designed to ensure a steady rise with age, and experience, for those considered worthy by appointment boards. The plateaux which have become established for those marking time on the second year registrar and fourth year senior registrar salaries were not envisaged and are quite contrary to the understanding and interpretation of the hospital staffing structure which was accepted by the profession in 1948. Table VII of Appendix V, for example, shows that this applies to 43 per cent of the registrars in the Scottish Western Region.
- (iii) The recent interim adjustment of 10 per cent to junior hospital staff had the effect of substantially restoring the Spens differentials between the junior and senior staffs which were disturbed in 1954, but the subsequent interim adjustment of 5 per cent to consultants again upset the original differentials.
- (iv) One object of the Consultant Spens Committee was to ease the financial strain during the early years for those who had embarked on a hospital career. The Spens betterment factor has never been properly applied to those in the hospital service and the present salaries are grossly below those estimated by the Spens Committee as being reasonable for those in the different junior grades.

91. Total life earnings are a crucial factor affecting prosperity and living standards. Delayed promotion, by lengthening the time spent in the lower grades, leaves a correspondingly shorter time in the higher ones, and thus reduces total life earnings, to an extent that can never be made up.

92. As has already been shown, delayed promotion already occurs to a serious degree, and the three major specialties—medicine, surgery, gynaecology and obstetrics—are among the worst affected. This has the paradoxical effect that consultants retiring from these specialties after 1980 will have achieved total life earnings much less than those of their contemporaries in other fields of specialist practice.

Performance of Consultant Work by Junior Staff

93. There is no doubt that because the average holder of a senior registrar post is older and more experienced than was formerly the case, the work allotted to him is correspondingly more advanced and responsible. Many have passed the age at which the Spens Committee expected them to gain a consultant post. They hold the appropriate qualifications and in many cases are doing the same type of work as a consultant.

94. The performance under proper supervision of increasingly advanced and responsible work is an essential part of training, and in the later stages the occasional performance of full consultant duties without any formal supervision is equally necessary. Such is the inadequate number of consultant posts and the increasing volume of work that it has become inevitable in many hospitals that senior registrars do work which should properly be undertaken by consultants. Such a situation means in effect the dilution of the consultant service and the payment at an inferior rate of doctors doing consultant work. The only effective remedy is to increase the number of consultant posts.

95. In the beginning of the Service, large numbers of young men coming out of the Forces after the war availed themselves of the opportunity of coming back to spend a period of time in hospital under the postgraduate further education scheme. Their value was quickly recognised, and many were retained as senior registrars or registrars. There have thus been so-called training posts far in excess of the prospective numbers of consultant vacancies. It was envisaged at that time that the consultant establishment would need to be substantially enlarged in order to provide a full consultant service in all parts of the country, and these training posts became a permanent part of the hospital establishment. The anticipated expansion has not materialised although the establishment in certain specialties has substantially increased.

Resident Posts

96. Hospital doctors who are compelled to be resident suffer certain disadvantages compared with non-residents. They are largely cut off from family and friends and the general stream of social and cultural life outside the hospital. They are obliged to accept food and quarters which are sometimes of a poor standard, and, finally, they have extra night work.

97. Before the National Health Service, most resident posts in hospitals were occupied by officers under 30, most of whom were unmarried. Accommodation was provided free and undoubtedly helped to attract applicants, providing some compensation for the disadvantages which residence entails.

98. Because of the delays already outlined, most of the resident registrars are now over 30: in the three main specialties markedly so, and a much higher proportion are married. In 1948 charges were introduced for board and lodging, so that the married resident is now obliged to pay for two homes, one outside the hospital for his wife and family and one inside the hospital for himself (as illustrated in the budget of Dr. B.—see Appendix IV). In 1956, the Ministry of Health pressed for and obtained increases in these charges on the grounds of increased costs and prices while at the same time refusing the profession's claim for increased remuneration based on the same grounds.

The Effect of the 1954 Award on Differentials

99. The recommendations of the Spens Committee entail a certain set of differentials between the salary range of consultants and those of lower grades. These differentials are accepted by the Council and Appendix VIII, Table I, shows the Spens proposals and the various rates which have operated since 1948.

100. It will be seen (Appendix VIII, Table II) that the differential between senior registrar and consultant salaries has risen from 20 per cent to 34 per cent.

Expenses

101. Mention is made elsewhere in this memorandum of the expenses incurred by hospital officers. What has been said applies also to hospital junior staffs.

102. In the performance of their duties, junior grades incur certain expenses. For all it is essential, both to carry out their work properly and also to secure recommendation for continued employment, to join medical societies and libraries, to subscribe to some appropriate specialist medical periodicals, and to buy new books. As already explained, it is also sometimes necessary for registrars and senior registrars to move to another region merely to secure continued employment in the same grade. Non-residents are frequently required to be available after leaving the hospital to give advice by telephone and to return to see patients (often emergency cases) and perhaps to operate on them. It is therefore necessary for them to have a car and a telephone, and selection committees sometimes enquire about this before making an appointment.

103. As in the case of the whole-time consultant, the full-time nature of the employment of junior staff not only means that the salary scale represents the total gross income, but also that it is all assessed on Schedule E for income-tax purposes. Therefore, no tax relief can be claimed for motor cars, telephone rentals, subscriptions to professional organizations and journals, etc. This bears heavily on the full-time junior staff, as these essentials represent a relatively larger proportion of their total income than in the case of the part-time senior staff, who can also claim for tax relief on them; e.g., in many hospitals the emergency surgical work is done at night by the senior registrar, who must maintain a telephone to be called by, and a motor car to transport him to the hospital to perform the operations. The registrar is, therefore, left to pay by far the major part of the capital costs of the car and telephone without financial or tax relief—items which cannot be borne without considerable sacrifice on the net income of those in this grade. Here again, adequate allowances are called for.

Results of the Present Conditions

104. In the past, promotion to consultant status was subject to intense competition at every stage. Such competition is essential if recruits of adequate quality are to be forthcoming to fill the consultant vacancies. It is certainly true that the present generation of senior registrars in the major specialties are the successful contestants of a hard-fought competitive struggle, but it is doubtful how much longer this state of affairs can be maintained. Already there is difficulty in attracting suitable candidates into the registrar grade. Tables I and II in Appendix VII show that many posts are now actually unfilled: many more can be filled only after repeated advertisement. The present shortage of registrars would in fact be much more serious were it not for overseas graduates coming to this country for postgraduate experience. Indeed without the help of these overseas practitioners the Hospital Service might well break down in some areas.

Proposed Remedies

105. The Council considers delayed promotion to be a most serious factor in under remuneration of hospital medical staff. It has already expressed the opinion that there should be an early review of hospital establishments and of the hospital staffing structure, and it welcomes the recent agreement between the Minister of Health and the Joint Consultants Committee to set up a Joint Working Party to study, in the light of experience of the Hospital Service since 1948 and of all other relevant considerations, the principles on which the medical staffing structure in the Hospital Service should be organized.

106. The figures already presented show that the main reason for delayed promotion is that there are insufficient consultant vacancies to allow a reasonable rate of progress through the senior registrar grade for the present number of senior registrars, and that this is particularly noticeable in certain specialties. The only effective solution is to increase the number of consultant posts and thus absorb those members of junior grades who are in point of fact already carrying out consultant duties. The promotions resulting from this can then be utilized to reduce the number of senior registrars and so avoid the present prolonged stay in the grade. Only in this way will it become a practicable possibility for a consultant post to be attained much closer to the age of 32. The consequent speeding up should in due course clear the present bottleneck between the registrar and senior registrar.

107. It is true that at any time, due to fluctuations in the rate of retirement, especially in certain specialties, the rate of promotion might be temporarily retarded. It is also true that the present solution could not instantaneously be implemented. For both these reasons, a number of interim and supplementary recommendations are proposed:

(1) *Extension of Salary Scales*

108. Emergency relief should be given to senior registrars who are already trained and who have been unable to obtain consultant posts. Such officers are the official trainee consultants of the Hospital Service, and it is the Council's view that, having been appointed by special committees in open competition for advertised posts in the training grade and having been allowed to pass all the efficiency bars during their training, the Government ought to retain them at an appropriately increased salary. The present practice of declaring them "transitional" and no longer on the official establishment is not satisfactory; employment on a yearly basis without increase in salary for increasing age and experience is a poor reward for the ten or more years of hard and highly skilled work which they have given to their hospitals. In most cases it is no fault of their own that these men have failed to get consultants posts—such posts properly required have not been made available.

109. Indeed, individuals retained after two years in the registrar or four years in the senior registrar grades are kept on because they are considered to be desirable recruits to the grade above, for which they have by that time gained the necessary experience, age, and qualifications. They are usually allocated increased responsibility as though they had been promoted, and it would be reasonable to allow such men security of tenure and further salary increments, so that the registrar overlapped the senior registrar and the latter continued to progress across the present gap separating him from the consultant's starting figure, reflecting in the salary what has taken place in the work performed. When such a registrar becomes a senior registrar a no-detriment clause should allow him to enter at the next figure above the one last attained in his old grade. In the case of the senior registrar this provision ought not to be necessary with seven possible annual increments after the normal four years in the grade.

(2) *Extra Increments on the Consultant Scale*

110. The Spens Committee recommended that specialists appointed before 32 should start one place lower down the incremental scale for each year under age, down to a maximum decrease of £250 (two years' increments) and those appointed over 32 could receive up to four increments' start in respect of age or special experience and qualifications.

111. In the Council's view, neither of these provisions is overworked. The former, though mandatory, is seldom applicable, and the latter is optional and not widely used. The present delay was, of course, quite unforeseen by the Spens Committee, and it is felt that it would be in line with their intentions to make both provisions obligatory, while removing the limit of four increments from the second one. This would make an enormous contribution to redress the total life earnings loss, because it would enable the top rate of pay to be reached at about 40 years and maintained for 25 years as originally intended.

(3) *Resident Posts*

112. When emoluments were free, and junior staff were generally younger and unmarried, residence in hospital was popular. As a result, many posts which in themselves could equally well be filled by a resident or a non-resident were always advertised as resident posts in order to attract applicants. This has led to the false belief that the posts in question were by some law of nature resident posts. In fact many posts above house officer which are resident in England are non-resident in Scotland. Re-examination of the resident registrar and senior registrar posts in England and re-classifying as non-resident wherever possible would lift a considerable load from many men in the position of Dr. B, whose budget appears in Appendix IV and who had to pay £14 3s. 4d. for hospital emoluments and £14 1s. 8d. for rent of flat, out of a monthly cheque of £63 11s. 11d.

113. If the present charges for residential emoluments are subsidized as the Ministry of Health asserts, a reduction of the number of resident posts would reduce the hospital costs, leaving both employer and employee better off. In those cases where residence is really essential (and there are some) a tax-free separation allowance for married men equal to the emoluments charged would be, in the Council's view, just, and in line with current practice in other occupations.

(4) *House Officers*

114. At the other extreme from the senior registrars who undertake a good deal of consultant work, it is only fair to point out that some so-called registrars do work which before 1948 was done by a senior type of house officer (usually two or three years qualified). Indeed some of the present establishment of registrar posts have been created by upgrading house officer and senior house officer posts which were difficult or impossible to fill, in the hope that the higher salary would attract applicants. That this is not wholly effective is shown by Tables I and II in Appendix VII. Nevertheless, it is clear recognition of the inadequacy of the house officer and senior house officer rates as a means of attracting doctors to stay in hospital longer, where they are so badly needed. In considering the remuneration of the house officer grades, it must be borne in mind that their occupants are fully qualified (even when only provisionally registered) and that their work is long and arduous.

(5) *Actual Salary Scales*

115. Appendix VIII shows in Table I the salary scales of hospital medical staffs at various relevant dates and in Table II the original ratios of the differentials proposed by the Spens Committee. Using the 1954 figure of £2,100 as the bottom rate for a consultant, the proper salaries for the other grades as in 1951 would be:

Senior house officer	...	40 per cent of £2,100=£840
Registrar	...	47 per cent-53 per cent of £2,100=£987-£1,113
Senior registrar	...	60 per cent-80 per cent of £2,100=£1,260-£1,680

The equivalent figures for 1957 rounded off, therefore, are:

Senior house officer	...	£840+29 per cent=£1,080
Registrar	...	£987-£1,113+29 per cent=£1,260-£1,440
Senior registrar	...	£1,260-£1,680+29 per cent=£1,620-£2,160

116. In the case of J.H.M.O.s—on which the Spens Report gives no guide—the correct salary scale for 1957 is £1,107-£1,593. Calculating similarly for house officers, the 1957 salaries should be 1st post—£558; 2nd post—£636; 3rd post—£718. In the view of the Council, the increments within the range should be as follows: Pre-registered house officers—£555; fully registered house officers, 1st post—£635; 2nd post—£715.

117. On this basis, the Council recommends the following scales of remuneration (in 1957 figures):

<i>House Officers</i>					
Pre-registered	...	...	...	...	£555
Fully registered, 1st post	...	...	...	...	£635
2nd post	...	...	...	...	£715
Senior house officer	...	...	...	...	£1,080
J.H.M.O.	...	...	...	...	£1,100-£1,600

Registrars and Senior Registrars. Taking the range £1,260-£2,160 above and allowing equal increments throughout, the figures when slightly smoothed out are:

Registrars	...	...	1st year	...	£1,260
			2nd year	...	£1,440
Senior registrars	...	...	1st year	...	£1,620
			2nd year	...	£1,800
			3rd year	...	£1,980
			4th year	...	£2,160

118. The above basic figures would, of course, be supplemented by the provisions outlined in subsection (1) above whereby persons retained in either grade beyond the normal period should receive further annual increments of £180, subsequently entering the grade above (if promoted) on a no-detriment basis.

SUMMARY OF THE COUNCIL'S MAIN RECOMMENDATIONS ON THE REMUNERATION OF HOSPITAL MEDICAL STAFFS

1. Salary Scales

The Council in its preliminary memorandum of evidence has shown that, on the basis of the fall in the value of money since the Danckwerts Award, which related to the year 1951, an adjustment of not less than 29 per cent is needed to restore the value of medical remuneration generally.

In the case of hospital medical staffs, the 1954 Award represented an upward adjustment in the salaries of consultants and other hospital medical staff designed and imposed by the Government broadly to restore the balance with general practitioner remuneration disturbed by the Danckwerts Award and to encourage recruitment to the Hospital Service. The Award was not related to the Consultant Spens Report, and was not accepted by the representatives of hospital medical staff as a settlement of their claim for the application of an adequate betterment factor to the rates of remuneration recommended by the Consultant Spens Committee. The present salary scales fall seriously short of even the 100 per cent increase deemed proper in 1951 for general practitioners. Moreover, merit awards, an integral and pensionable part of total remuneration, and the fees for domiciliary consultations have remained unchanged since 1948.

The Council recommends the introduction of the salary scales set out in the following table, which also shows the present rates of remuneration of the various grades and, where appropriate, the remuneration recommended by the Consultant Spens Committee in terms of the 1939 value of money:

Grade	Spens Scales	Present Scales (1954 Award)	Scales now Recommended
House officer	—	£425-£525	Pre-registered £555 Fully registered, 1st post £635 2nd post £715
Senior house officer	£600	£745	£1,080
J.H.M.O.	—	£775-£1,075	£1,100 × £100 (5) - £1,600
Registrar	£700-£800	£850-£965	£1,260 × £180 - £1,440
Senior registrar	£900-£1,200	£1,100-£1,400	£1,620 × £180 (3) - £2,160
S.H.M.O.	—	£1,575-£2,025	£2,160 × £130 (8) - £3,200
Consultant (basic scale)	£1,500-£2,500	£2,100-£3,100	£2,700 × £162 10s. (8) - £4,000
" (C merit award)	£2,000-£3,000	£2,600-£3,600	£3,500-£4,800
" (B " ")	£3,000-£4,000	£3,400-£4,400	£5,100-£6,400
" (A " ")	£4,000-£5,000	£4,300-£5,300	£6,700-£8,000

2. Domiciliary Consultations

The Council considers that the payments for domiciliary consultations and the expenses and fees paid in connexion with such consultations should be increased by 60 per cent. In addition the restriction on the first eight consultations for whole-time consultants should be abolished.

3. Expenses

The vast majority of hospital medical staffs at all levels incur certain expenses which are essential to the practice of medicine and to the efficiency of the Hospital Service. The Spens Committee drew attention to the need for the payment of adequate expense allowances, and furthermore suggested that such expenses should be recognized for income-tax purposes. At the present time whole-time medical staff in the Hospital Service are neither reimbursed nor allowed tax remission for

these expenses. The Council considers that this anomalous situation should be remedied by the payment of adequate expenses by the Hospital Service.

4. Calculation of Part-time Consultant Salaries

The weighting factor used in calculating the proportion of the whole-time salary scale which should be paid to the part-time consultant should be restored to the level which operated prior to the 1954 Award, namely $1\frac{1}{2}$ sessions.

5. Senior Hospital Medical Officers

In the suggested salary scales for hospital medical staffs set out above, the Council has recommended that S.H.M.O.s should be remunerated at a rate equivalent to 80 per cent of the scale for consultants. The Council wishes to emphasize that this scale should be but an interim measure pending the abolition of the grade.

6. Extension of Salary Scales in Registrar Grades

Registrars and senior registrars retained in either grade beyond the normal period should receive further annual increments of £180, subsequently entering the grades above, if promoted, on a no-detriment basis.

7. Additional Increments on Consultant Scale for Delayed Promotion

The remuneration of those promoted to consultant rank should be related to the starting point envisaged by the Consultant Spens Committee, i.e., age 32. Those appointed over 32 years of age should commence with appropriate increments in respect of age or special experience or qualifications.

Note: The British Medical Association's Second Supplementary Memorandum of Evidence was accompanied by eight Appendices, of which the following are already available in public form:—

Appendix I. Extract (paragraph 27) from Ministry of Health Circular R.H.B. 49/85.

Appendix II. Ministry of Health Circular R.H.B. 50/96 on the Senior Hospital Medical Officer Grade.

APPENDIX III

FIGURE 1

CONSULTANT AND S.H.M.O. SALARY SCALES COMPARED

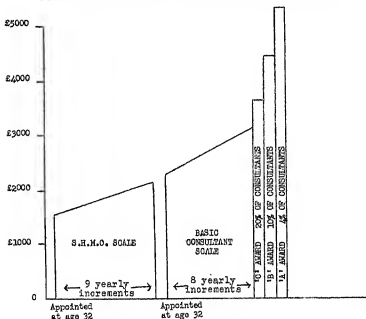
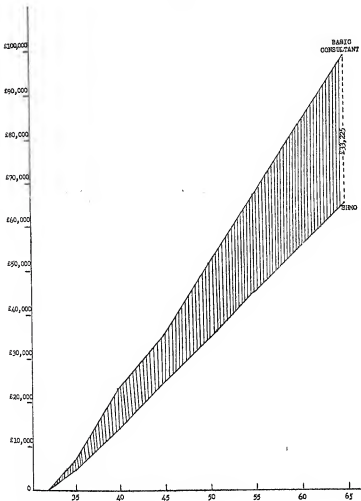


FIGURE 2

TOTAL LIFE EARNINGS OF CONSULTANT ON BASIC SCALE AND S.H.M.O.
ASSUMING BOTH APPOINTED AT AGE 32



APPENDIX IV

BUDGET I

Dr. A, M.B., B.S., M.R.C.P., M.D.

Senior Hospital Scholarship, 1943. Prize in Practical Medicine, 1943. Age 37.

Non-Resident Senior Medical Registrar 5th year. Since qualification, 8 years at teaching hospital, 2½ at non-teaching hospital with very close affiliation to teaching hospital, and 3½ years in the Army. Married—3 children (10, 8, and 4 years).

Total salary £1,540 per annum since April, 1957 (previously £1,400). After deductions for superannuation, national insurance, income tax, and hospital meals, monthly salary—£103.

Expenses:								£ per month
Repayment of Building Society and interest on other loans								25
Rates—Schedule A								4
Life insurance								8 10
Car								12
Heating and lighting								5 10
*Telephone								2
School fees								17
Subscriptions								1 10
								<u>£75 10</u>

* Professionally necessary, but no allowance, or tax rebate.

This leaves about £28 per month, or £7 per week, for food, clothes, laundry, holidays, all household requisites, etc., for a family of five. Additional earnings from lectures, coaching, marking papers and the like are fluctuant and small and do little to prevent the ever-increasing load of debt.

BUDGET II

Dr. B, M.B., F.R.C.S. (16 years qualified).

Resident Senior Surgical Registrar 3rd year. Age 39.

Married—2 children (13 and 7 years).

Gross salary—£1,430.

Net salary—£1,055

1,055 0 0

Expenses:												
House	Mortgaged											
	Interest and repayment	...	...	...	210	0	0		
	Rates and ground rent	...	...	...	51	0	0		
	Water rate	...	...	...	2	10	0		
	Heating	...	...	...	42	0	0		
	Telephone	...	...	...	16	0	0		
	Maintenance	...	...	...	70	0	0		
	Car	Tax and insurance	32	10	0				
	Running costs	...	...	...	110	0	0		
	N.H.S. allowance									98	0	0
	Repayments	98	0	0				
Education	100	0	0				
Clothing	90	0	0				
Housekeeping, etc.	337	0	0				
Personal insurance	40	0	0				
Entertainments	30	0	0				
Holidays	Nil						
Medical expenses, etc.	15	0	0				
Children's allowance				21	0	0	
						£1,244	0	0	£1,174	0	0	

Income tax, superannuation, and national insurance, plus residential emoluments, included in difference between gross and net salary. No allowance for depreciation of house and car.

BUDGET III

Dr. C, M.B., Ch.B., 6 years qualified, ex-Service. Age 29.

Resident Surgical Registrar 2nd year. Married—one child.

Salary, £965 per annum.

Monthly salary after deduction of tax, insurance, and superannuation—£63 11s. 11d.

Expenses:

Residential emoluments	14	3	4
Rent of flat	14	1	8
Subscriptions, exam. fees, books	4	15	0
Insurance	2	2	3
Heat and light	2	15	0
No car or telephone			

£37 17 3

This leaves £25 14s. 8d. per month.

Allowing for five-week months, this is about £6 5s. per week for housekeeping, clothes, holidays, and all forms of pleasure.

BUDGET IV

Dr. D. Age, 30.

Married—2 children (1½ and 4½ years).

Senior House Officer, Medicine—6 months.

Registrar, Psychiatry—6 months.

Gross salary—£877 0 0.

Net salary—£744 0 0. 744 0 0

Expenses:

House	Mortgaged								
	Interest and repayment	144	0	0					
	Rates and ground rent	40	0	0					
	Water rate	4	0	0					
	Heating	24	0	0					
	Telephone	13	0	0					
	Maintenance	40	0	0					
Car	Tax and insurance	35	0	0					
	Running costs	68	0	0					
	N.H.S. allowance				77	0	0		
	Repayments	52	0	0					
Education	... ..	Nil							
Clothing	... ..	40	0	0					
Housekeeping (food, running expenses, papers, personal expenses, electricity and gas)		294	0	0					
Personal insurances		22	0	0					
Entertainments		10	0	0					
Holidays		40	0	0					
Medical expenses (journals, defence, books, societies, exam. fees, and expenses)		44	0	0					
Children's allowance					16	0	0		
		£870	0	0	£837	0	0		

Deficit £33 0 0.

Income tax, superannuation, and national insurance included in difference between gross and net salary.

No allowance for depreciation of house and car.

BUDGET V

Dr. E. Age, 29.

Married—1 child (2 years).

Senior House Officer.

Gross salary—£820 0 0.

Net salary—£730 0 0.

730 0 0

Expenses:

House	Mortgaged								
	Interest and repayment ...	...	...	...	180	0	0		
	Rates and ground rent ...	...	...	...	46	0	0		
	Water rate ...	...	...	...	4	0	0		
	Heating ...	...	...	...	60	0	0		
	Telephone ...	...	...	...	15	0	0		
	Maintenance ...	...	...	...	20	0	0		
Car	Tax and insurance ...	...	...	...	25	0	0		
	Running costs ...	...	...	...	125	0	0		
	N.H.S. allowance ...	...	...	...				40	0 0
Education	...	...	...	...	Nil				
	Clothing and housekeeping (food, running expenses, papers, personal expenses) ...	...	...	...	400	0	0		
	Personal insurances ...	...	...	...	55	0	0		
	Entertainments ...	...	...	...	15	0	0		
	Holidays ...	...	...	...	55	0	0		
	Medical expenses (journals, defence, books, societies) ...	...	...	...	25	0	0		
								£1,025	0 0
								£770	0 0

Income tax, superannuation, and national insurance included in difference between gross and net salary. No allowance for depreciation on house and car.

Balance made up by wife's earnings.

BUDGET VI

Dr. F. Age, 24.

Married—no children.

House Officer.

Gross salary—£467 10 0.

Net salary—£290 0 0.

290 0 0

Expenses:

House	Rent ...	...	...	...	150	0	0		
	Rates and ground rent ...	...	...	...	13	0	0		
	Water rate ...	...	...	...	3	0	0		
	Heating ...	...	...	...	25	0	0		
	Telephone ...	...	...	...	12	0	0		
	Maintenance ...	...	...	...	15	0	0		
Car	...	...	...	...	Nil				
Education	...	...	...	...	Nil				
Clothing	...	...	...	...	40	0	0		
	Housekeeping (food, running expenses, papers, personal expenses) ...	...	...	...	125	0	0		
	Personal insurances ...	...	...	...	40	0	0		
	Entertainments ...	...	...	...	5	0	0		
	Holidays ...	...	...	...	30	0	0		
	Medical expenses (journals, defence, books, societies) ...	...	...	...	10	0	0		
								£468	0 0
								£290	0 0

Income tax, superannuation, and national insurance included in difference between gross and net salary plus resident charges at hospital. No allowance for depreciation on house and car.

Balance made up by wife's earnings.

APPENDIX V

TABLE I.—*Showing the numbers and average ages of all Consultants and Senior Registrars in all specialties in each Region and in Scotland as a whole at 31.12.56*

	Northern Region						North-Eastern Region						South-Eastern Region						Western Region						Total Scotland					
	Consultants			Senior Registrars			Consultants			Senior Registrars			Consultants			Senior Registrars			Consultants			Senior Registrars			Consultants			Senior Registrars		
	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age	No.	Av. Age
General medicine ...	4	49.5	1	35.0	12	50.8	3	52.7	19	52.9	5	39.6	40	48.5	12	36.2	65	49.1	22	35.8	160	49.6	43	36.0						
Fever ...									1	43.0							8	52.0	2	34.0	10	52.2	2	34.0						
V.D. ...					1	69.0			1	52.0			2	55.0			2	51.5			6	54.2								
Chest diseases ...	1	55.0			3	50.0			4	43.8	1	37.0	9	44.3	2	34.5	20	48.6	5	32.8	37	47.3	8	33.8						
Dermatology ...			2	47.0	1	40.0	2	51.0	1	40.0	1	40.0	3	50.0	1	37.0	7	53.0	4	39.8	14	51.2	7	39.4						
Neurology ...													3	42.7			3	47.0			6	44.9								
Homoeopathy ...																														
General surgery ...	5	53.6	1	34.0	11	53.5	6	32.7	11	49.1	4	36.3	28	46.5	10	36.7	67	47.1	15	35.6	122	48.2	36	36.4						
Orthopaedics ...	2	45.5	1	32.0	5	40.6	1	30.0	5	40.4	2	34.5	9	51.4	2	37.5	20	45.5	5	37.0	41	45.6	11	35.5						
Neuro-surgery ...			2	43.5									3	45.3	1	35.0	3	46.7	1	32.0	8	45.4	2	33.5						
Thoracic surgery ...			2	43.5	1	36.0	1	36.0	1	48.0	1	34.0	4	41.5	2	33.5	4	44.0	1	37.0	11	43.4	5	34.8						
Dentists ...			3	55.0					6	40.5			12	52.9	1	44.0	11	52.6	3	35.7	32	50.7	4	37.8						
E.N.T. ...	2	43.0			4	45.5	1	34.0	4	44.0			8	53.0	4	34.8	23	49.8	4	32.8	41	49.2	9	33.8						
Plastic surgery ...													2	42.5	1	35.0	3	44.0	1	36.0	5	43.4	2	35.5						
Urology ...													2	50.0	1	35.0	7	51.0	2	37.0	9	50.8	3	35.7						
Ophthalmology ...	2	43.0			4	48.3	1	41.0	3	48.3	2	33.5	6	49.5	4	32.0	22	50.5	5	32.6	37	49.5	12	33.3						
Obst. and gynaec. ...	2	44.5	2	34.0	6	43.8	1	32.0	7	45.9			18	51.3	5	36.8	34	48.0	12	36.0	67	48.2	20	35.8						
Pædiatrics ...	1	45.0	1	32.0	3	48.7	1	37.0	3	48.3			11	46.7	3	33.3	15	45.1	3	34.0	33	46.3	8	34.3						
Pathology ...	2	53.0			3	46.0			5	42.8	1	34.0	7	50.0			29	45.2	22	34.7	46	46.1	23	34.7						
Bacteriology ...					5	46.0			3	53.0			7	49.7			11	46.4	7	33.3	26	48.0	7	33.3						

APPENDIX V—continued

	Northern Region						North-Eastern Region						Eastern Region						South-Eastern Region						Western Region						Total Scotland					
	Consultants			Senior Registrars			Consultants			Senior Registrars			Consultants			Senior Registrars			Consultants			Senior Registrars			Consultants			Senior Registrars			Consultants			Senior Registrars		
	No.	Av. Age		No.	Av. Age		No.	Av. Age		No.	Av. Age		No.	Av. Age		No.	Av. Age		No.	Av. Age		No.	Av. Age		No.	Av. Age		No.	Av. Age		No.	Av. Age				
Radiology ...	2	43-0	1	35-0	3	55-3	2	32-5	2	32-5	6	52-16	2	36-5	17	44-0	3	32-5	26	50-4	3	33-3	54	48-6	11	33-6										
Radiotherapy ...						1	60-0				2	44-5			5	41-0	4	33-3	6	49-7	1	30-0	14	45-4	5	32-6										
Psychiatry ...	2	35-5	1	34-0	8	48-9	2	31-0	8	49-3	1	31-0	1	31-0	12	47-8	5	34-4	37	46-1	7	33-6	67	46-8	16	33-4										
Anaesthetics ...	1	45-0	1	33-0	5	50-8	2	30-0	6	42-3	2	32-5	2	32-5	21	47-2	5	33-8	36	46-9	6	33-5	69	46-8	16	33-0										
Physical medicine ...						1	43-0																													
Blood transfusion ...																																				
Total ...	26	48-3	9	33-7	84	48-7	22	33-2	58	47-0	22	35-8	230	48-0	66	35-1	459	48-0	131	34-9	897	48-0	250	35-0												

TABLE III.—Showing Consultant vacancies in Scotland during next 5 years with total numbers of Consultants and Senior Registrars and the existing ratio between these two grades

	Total No. of Consul- tants	Average Age	Total No. of Senior Registrars	No. Already Served 4 Years or More	Average Age	Consultant Vacancies in Next 5 Years						Ratio: Consul- tants to Senior Registrars
											5 Years' Total	
						1957	1958	1959	1960	1961		
General medicine ...	140	49.6	43	15	36.0	1	2	3	3	3	12	3.3 : 1
Fever ...	10	52.2	2		34.0			1		1	2	5 : 1
V.D. ...	6	54.2										
Chest diseases ...	37	47.3	8	1	33.8							4.6 : 1
Dermatology ...	14	51.2	7	6	39.4				1	1	2	2 : 1
Neurology ...	6	44.8										
Homoeopathy ...	122	48.2	36	9	36.4		2	2	4	2	10	3.4 : 1
General surgery ...	41	45.6	11	1	35.5					1	1	3.7 : 1
Orthopaedics ...	8	45.4	2	1	33.5							4 : 1
Neurosurgery ...	11	43.4	5	1	34.8							2.2 : 1
Thoracic surgery ...	32	50.7	4		37.8	1					1	8 : 1
Dentists ...	41	49.3	9		33.8	1		1	3	2	7	4.6 : 1
E.N.T. ...	5	43.4	2		35.5							2.5 : 1
Plastic surgery ...	9	50.8	3		35.7				1		1	3 : 1
Urology ...	37	49.5	12		33.3		1	1	1	2	5	3.1 : 1
Ophthalmology ...	67	48.2	20	7	35.8	1	1	1	2	1	6	3.5 : 1
Obst. and gynae. ...	33	46.3	8		34.3			1			1	4.1 : 1
Paediatrics ...	46	46.1	23		34.7			2	1	1	4	2 : 1
Pathology ...	26	48.0	7		33.3	1					1	3.7 : 1
Bacteriology ...	54	48.6	11		33.6		3		2		5	4.9 : 1
Radiology ...	14	45.4	5		32.6							2.8 : 1
Radiotherapy ...	67	46.8	16		33.4		1	2	2		4	4.2 : 1
Psychiatry ...	69	46.8	16		33.4			1	3	1	7	4.3 : 1
Anaesthetics ...	1	43.0										
Physical medicine ...	1	41.0										
Blood transfusion ...												
Totals	897	48.0	250	41	35.0	6	10	15	23	15	69	3.6 : 1

TABLE IV.—*Consultant vacancies in Scotland for the two 5-year periods, 1957-61 and 1977-81*

	1957	1958	1959	1960	1961	Total	1977	1978	1979	1980	1981	Total
General medicine	1	2	3	3	3	12	8	7	8	10	11	44
Fevers ...			1		1	2	2		2			4
V.D. ...							2	4	1		2	9
Chest diseases				1	1	2			1		1	2
Dermatology									1			
Neurology												
Homoeopathy												
General surgery		2	2	4	2	10	8	8	6	8	6	36
Orthopaedics					1	1	1	1		6	3	11
Neurosurgery												
Thoracic surgery						1	2	1	1	2	1	7
Dentists	1					7		2	2	1	3	8
E.N.T. ...	1		1	3	2			1	1	1	1	2
Plastic surgery								2				
Urology				1		1		1		1		2
Ophthalmology		1	1	1	2	5	1	1	1	1	1	5
Obst. and gynaec.		1	1	2	1	6	7	3	5	2	2	19
Paediatrics	1		1			1	6	2	1	1	3	12
Pathology			2	1	1	4	2	3	4	3	4	16
Bacteriology	1					1	1	1	2	2	3	6
Radiology		3		2		5	3	4	4	0		16
Radiotherapy							3	2				5
Psychiatry			2	2		4	2	3		8	4	17
Anaesthetics		1	1	3	1	7	2	3	5	6	2	18
Physical medicine	1						4	1	1			1
Blood transfusion											1	1
Totals ...	6	10	15	23	15	69	54	45	44	51	49	243

TABLE V.—*Showing sources and previous grades of Consultants appointed to the Western Region of Scotland in 1953–55*

*New appointments 44	Posts filled by applicants from outside Region 32
Replacements 66	Posts filled by applicants from inside Region 66
	Posts filled by applicants from university 5
	Others... .. 7
Consultant posts filled from inside Region 66	Consultant posts filled from outside Region 32
Previous grade consultant 23	Previous grade consultant 12
Previous grade S.H.M.O. 26	Previous grade senior registrar 14
Previous grade senior registrar 17	Previous grade registrar 1
	Previous grade university 4
	Others 1

* S.H.M.O. Review, 1953.

As a result 26 S.H.M.O.s were regraded consultant. This necessitated the creation of 26 new consultant posts. These are not included in the figures given above.

TABLE VI.—*Showing the previous grades of all Consultants appointed in Scotland during the last 3 years (1953–56 for the Western Region)*

Region	Previous Grade				Total Consultant Posts
	Consultant	S.H.M.O.	Senior Registrar	Other	
North	—	4 (4)	1 (1)	—	5 (5)
North-East	—	1 (1)	6 (2)	—	7 (3)
East	8 (2)	3 (2)	5 (4)	1	17 (8)
South-East	5 (1)	10 (9)	25 (18)	1 (1)	41 (29)
West	35 (23)	26 (26)	31 (17)	18 (12)	110 (78)
All Scotland	48 (26)	44 (42)	68 (42)	20 (13)	180 (123)

Figures in parentheses denote local candidates.

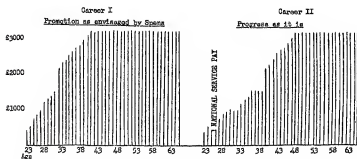
TABLE VII.—*Showing the total number of Registrars in the Western Region of Scotland, and the length of time each has held his appointment*

	1 Year	2 Years	3 Years	4 Years	5 Years	6 Years	7 Years	8 Years	University	Total No.
Medicine ...	9	5	6	3	—	—	4	1	1	29
Surgery ...	9	4	8	4	2	1	1	—	1	30
Anæsthetics ...	4	3	3	—	—	1	—	—	—	11
Dermatology ...	1	—	—	—	1	1	—	—	—	3
Ear, nose, and throat ...	1	5	2	1	—	—	—	—	—	9
Infectious diseases ...	1	—	—	—	—	—	—	—	—	1
Obstetrics and gynaecology ...	2	3	5	2	—	—	—	—	—	12
Ophthalmology ...	2	2	1	—	—	—	—	—	—	5
Orthopaedics ...	2	1	—	—	—	—	—	—	—	3
Paediatrics ...	—	—	1	2	—	—	—	—	—	3
Pathology ...	6	3	4	—	—	1	—	—	—	14
Psychiatry ...	6	5	2	—	—	—	1	—	—	14
Radiology ...	2	—	1	—	—	—	—	—	—	3
Thoracic surgery ...	1	—	—	—	—	—	—	—	—	1
Tuberculosis ...	—	1	1	—	—	—	—	—	—	2
Bacteriology ...	3	—	1	—	—	—	—	—	—	4
Total number registrars ...	49	32	35	12	3	4	6	1	2	144

APPENDIX VI

FINANCIAL RESULTS OF DELAYED PROMOTION

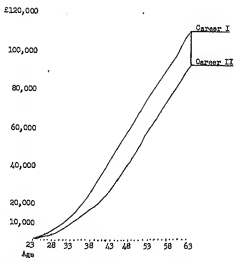
FIGURE 1



Both graphs show a salary for each year of age between 23-65. The hatched area is therefore proportional in size to the total life earnings.

FIGURE 2

This shows the sum total earned in the N.H.S. at each year of age, and again illustrates the permanent and irretrievable nature of the loss due to delayed promotion (based on an 11-session appointment).



APPENDIX VII

TABLE I.—*Report to Sheffield R.H.B. by the Board's medical committee, reported in "Manchester Guardian," Saturday, 7th April, 1956*

A. Registrar posts advertised September, 1955–March, 1956.

Posts advertised	106	No. of applicants for 76 posts	185
No. of posts for which no applications received ...	30	British subjects	54
Applications received for ...	76	Non-British graduates of U.K., Irish, and Commonwealth universities ...	7
	106	Other	124
			185
			185

B. Current schedule of advertisements for registrars.

No. of posts	21	No. of applicants for 17 posts	37
No. of posts for which no applications received ...	4	No. from universities in U.K.	11
Applications received for ...	17	No. from universities outside U.K.	26
	21		37
			37

TABLE II.—*Registrar Posts in Region X January–December, 1956. (Information kindly supplied by R.H.B., subject to anonymity)*

Number of posts—80

	No. of posts
Advertised once	59
" twice	12
" thrice	5
" four times	4
	80

Fate of 114 advertisements

No applications received	48
Applicants with qualifications gained outside the British Isles only	27
Foreign and British applicants with British qualifications	39
	114

Posts filled and unfilled (includes the 80 posts listed above and others not falling vacant during the period surveyed)

Posts filled by British graduates	74
" " other graduates	41
" unfilled	18

NOTE.—These figures apply to all specialties not just the three major ones.

APPENDIX VIII

TABLE I

	Spens	1948-54	1954-7	1957— Interim Award
F.T. Cons	£1,500-£2,500 ×£125 in 8 years	£1,700-£2,750	£2,100-£3,100	£2,205-£3,255
Grade I—S.R. ...	£900-£1,200 ×£100 in 4 years	£1,000-£1,300	£1,100-£1,400	£1,210-£1,540
" II—Reg. ...	£700-£800 in 2 years	£775-£890	£850-£965	£935-£1,061 10s.
" III—S.H.O.	£600	£670	£745	£819
H.O.		£350-£450	£425-£525	£467 10s.— £577 10s.
J.H.M.O.		£700-£1,000	£775-£1,075	£852 10s.— £1,182 10s.
R.A.M.C.—Lt. ...			£762	
Capt. ...			£872	

TABLE II

	Spens	1948-54	1954-7
Consultant F.T. Min.=100%	100% (£1,500)	100% (£1,700)	100% (£2,100)
	↙ 20% ↘	↙ 24% ↘	↙ 34% ↘
Grade I—S.R.	60-80%	59-76%	52-66%
" II—Reg.	47-53%	45-52%	40-46%
" III—S.H.O.	40%	39%	35%
H.O.	—	21-26%	20-25%
J.H.M.O.	—	41-39%	37-51%

THIRD SUPPLEMENTARY MEMORANDUM OF EVIDENCE

presented by the British Medical Association to the Royal Commission on Doctors' and Dentists' Remuneration, June 1958

1. The terms of reference of the Royal Commission require it to consider how the levels of professional remuneration now received by doctors taking any part in the National Health Service compare with the remuneration received by members of other professions, by other members of the medical profession, and by people engaged in connected occupations.

2. In addition, the Commission itself made a public statement on 12th April, 1957, and indicated that, though not asked to recommend remuneration for doctors employed by local authorities, such doctors would be among the "other members of the medical profession" on whose remuneration evidence would be received for purposes of comparison.

3. It follows from all this that although the remuneration of certain sections of the profession is said to be outside the Commission's remit, evidence is necessary for purposes of comparison, and this Third Supplementary Memorandum deals with the position of public health medical officers, university medical teachers and research workers, and medical officers in the Armed Forces. In all these fields the scales of remuneration have always fallen short of the rates achieved for general practitioners and hospital medical staffs in the National Health Service. In the Council's view the present rates of remuneration in these fields of practice are most unsatisfactory and are therefore entirely inappropriate standards by which to compare the remuneration of family and hospital doctors in the Health Service.

4. The succeeding sections of this memorandum outline the unsatisfactory position which has developed and recommend scales of remuneration which would be more appropriate in conditions as they exist today.

5. The Council contends that, if the Commission seeks to determine the proper current levels of remuneration for doctors in the National Health Service by comparing them with the rates received by other members of the profession outside its remit, it should do so, so far as public health doctors, university staffs, and medical officers in the Armed Forces are concerned, by reference to the scales recommended below and *not* to the existing scales, which are seriously inadequate and a source of great dissatisfaction to those concerned.

6. Finally, the opportunity is taken in this memorandum of presenting evidence on behalf of ophthalmic medical practitioners taking part in the Supplementary Ophthalmic Service.

THE POSITION OF THE PUBLIC HEALTH DOCTORS

7. Since the Royal Commission will not pronounce on the salaries of the public health medical officers but will look at these salaries only for the purposes of comparison, it seems unnecessary to submit to the Commission an exhaustive account of the many and diverse responsibilities undertaken by the doctors engaged in this branch of medical work; but should the Commission desire any information additional to that contained in this memorandum, the Association will gladly supply it.

8. In the paragraphs which follow, the importance of preventive medicine is stressed, the defects of the present structure of staffing and remuneration in the public health medical service are indicated, and proposals for reform are made.

9. There are two matters which it is desired to emphasise at the outset. First, it is the considered view of the Association that the present financial position of the public health doctors is most unsatisfactory, and therefore by no means an appropriate standard by which to determine the proper remuneration of the family doctors and the hospital doctors. Repeated but unsuccessful attempts have been made to improve the lot of the public health doctors by bringing their remuneration into reasonable relationship with that of the other main sections of

the profession. Any attempt now to bring these other sections down to the level of their inadequately paid colleagues would be absurd.

10. Secondly, the new salary structure which the Association now proposes for the public health doctors has been worked out in relation to the net incomes earned in general and hospital practice as at March, 1958.

The Importance of Preventive Medicine

11. The medical officer of health is the specialist in preventive and social medicine. He has the statutory function of ascertaining, reporting, and advising upon all conditions which affect the health of the community. As the guardian of the community health, he is the leader of a team of medical colleagues and ancillary workers engaged in a wide variety of medical and medico-social services, both environmental and personal.

12. In recent years, as a result of advances in medical knowledge and in social legislation, the scope of public health practice has been considerably widened, and it continues to expand. The maintenance of healthy conditions in the physical environment is still of great importance, and in this field the medical officer of health exercises statutory powers under many Acts, Regulations, and Orders concerned with the prevention of such dangers to health as bad housing, adulterated and infected foods, and polluted water and milk supplies. He also continues to perform his traditional and highly important role as an expert epidemiologist in connection with the prevention of the spread of infectious diseases. And within the sphere of the personal health and education services he has great and growing responsibilities.

13. These personal services include, for example, ante-natal and post-natal care; domiciliary midwifery; the home nursing and home help services, which enable the sick and the aged and infirm to be cared for, in suitable cases, in their own homes—an arrangement which causes both satisfaction to the patient and saving to the State; the ascertainment of physical defects in children and mental defect at all ages; the regular medical supervision of the school child in order that he may derive the greatest possible benefit from the education he receives and later take his place in the community as a fit and healthy young person; the supervision of those so gravely handicapped, physically or mentally, as to need special care or special schooling; the provision of residential accommodation and social services for the aged; and various measures of health education—including the education of parents in the care and training of young children—which contribute in important ways to the promotion of health, bodily and mental.

14. In much of this work the medical officer of health, with his staff, is closely associated both with the family doctor and with the hospital, providing as he does the link through which the public health "field" services are brought to the support of their therapeutic tasks. Through the provision of "care and after-care," which the National Health Service Acts made a statutory duty of the local health authority, the medical officer of health operates, as has already been indicated, a variety of medico-social services designed to assist the treatment of the sick and their rehabilitation after illness. The home nurse has long been a trusted and indispensable ally of the general practitioner, who is now coming to appreciate more and more the advantages of the co-operation provided by the health visitor. So far as the hospital is concerned, the public health team is in a position to help by supplying background reports from its knowledge of the patient's personal and environmental problems and difficulties, by undertaking sociological work as necessary while the patient remains in hospital, and by making available the resources of such social agencies as are needed to assist the patient's eventual readjustment to life in the community.

15. In the field of mental health the local health authorities now have a prospect of a great enlargement of their present important responsibilities as a result of the far-reaching proposals of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1954-1957). The Commission recommended a general reorientation of the mental health services away from institutional care in its present form and towards community care, and considered it essential that

the central direction of the community services for mentally disordered patients should be in the hands of the medical officer of health.

16. The control of infectious disease through such measures as the extensive scheme of vaccination against poliomyelitis now in progress, the clearing away of slums and the evils that they breed, the maintenance of the purity of food and drinking water, the prevention of unnecessary disability in old age, the promotion of safe child-bearing, the endeavour to ensure that the child will grow up to manhood with a sound mind in a sound body, the care of those who by reason of congenital defect or the effects of injury or disease are unable to lead an unsheltered existence—such, then, are some of the operations of preventive medicine. They proceed quietly and undramatically. They lack the glamorous appeal to the popular imagination of the wonders of cardiac and cerebral surgery. But to understand their immense importance one has only to contemplate the part they have played in the triumphs of the past, such as the remarkable decline in maternal and infant mortality and the virtual eradication of a number of killing infectious diseases. At the present time a formidable challenge is presented to preventive medicine by the problems of the ageing population and the high incidence of mental disorders in the community. Prevention is both better and cheaper than cure, and there is no doubt that the resolute prosecution of preventive measures, planned and administered by men and women of ability and vision and enterprise in the medical service of the Local Government Authorities, can produce results of incalculably great value in terms of human happiness, of industrial productivity, and of saving to the national Exchequer.

17. If, however, the benefits of preventive medicine, to the individual and to the community, are to be fully secured, it is essential that the financial prospects in the public health medical service should be such as to attract its proper proportion of the more able young doctors. As long ago as 1910, a memorandum issued by the Local Government Board (the predecessor of the Ministry of Health) contained this statement: "The salary offered to the Medical Officer of Health who devotes his whole time to public health work should, in the Board's view, be sufficient to attract men with good qualifications and to retain their services. The Medical Officer should not be placed in a position of inferiority in this respect to other medical men in the district. . . . It is not sufficient that a medical man is found to accept the salary offered; it is more important that the salary should be such that it will be worth the while of a capable man to accept it."

18. The importance of giving the public health doctor a financial status comparable with that of his professional colleagues is perhaps even greater to-day than it was half a century ago, both because of his increased responsibilities and because he now has more close and frequent contacts with the family doctors and the hospital doctors and must be able to meet them on terms of equality if his counsels are to be given due weight and if a fully co-operative relationship, so important to the smooth functioning of the Health Service, is to be maintained. In a paper published three years ago, the late Dr W. G. Patterson, then Senior Administrative Medical Officer of the Newcastle Regional Hospital Board, wrote that, "it must be suggested in all seriousness that one of the chief failures in co-operation between the hospital and the local health authority service lies in the division of the medical profession into two salaried camps of grossly unequal status."

19. Unhappily, the financial rewards in the public health medical service to-day continue to be such as are failing to attract a sufficient number of recruits of the highest quality, capable of becoming outstanding leaders in the battle of preventive medicine in the future. There is no need to emphasize the ominous significance of the following extract from the latest annual report of the Medical Officer of Health for Hertfordshire: "In the past five years six men have taken their first public health jobs in this county, and after service averaging one and a half years, four have left to find more lucrative employment. Several have expressed to me their real regret at leaving work which they found enjoyable and their embarrassment at having so soon made the decision to desert a service in which they had hoped to make a career. The usual explanation was that both the immediate rewards and the opportunity for advancement in our public health services are limited in comparison with those in other branches of the profession. This experience is shared with most of my

colleagues who have been able to recruit young men to their staff. This lack of men fitting themselves for senior appointments in the local authority health services in years to come is disturbing."

The Present Career Structure

20. The doctor entering the public health medical service receives his first appointment in the grade of "medical officers in departments." He is commonly described as an assistant medical officer, and for the sake of simplicity this title is used in the paragraphs which follow.

21. Before entering the service the doctor will have completed the same basic professional training, including the pre-registration year in resident hospital appointments, as his colleagues who choose other medical careers. He may have remained in the Hospital Service for a time, or gained some other form of further professional experience, after becoming fully registered. He may have studied for higher examinations and gained an additional degree or post-graduate diploma. If he has the ambition to rise to the top of his chosen branch of the profession he will certainly have acquired the postgraduate Diploma in Public Health, which he must possess in order to be eligible for a major appointment as medical officer of health—a requirement which is unique in the medical profession in being a *statutory* one. The qualification of D.P.H. is usually taken after a course of whole-time study occupying a full academic year, during which the student cannot undertake a remunerative post. Many public health doctors hold additional higher qualifications, such as the degree of Doctor of Medicine or the diploma of Membership of a Royal College of Physicians; and some are barristers at law.

22. The assistant medical officer is engaged in clinical, as distinguished from administrative, duties. He may work in the schools or at ante-natal and post-natal clinics or at child welfare centres. Commonly he undertakes a combination of these or other tasks.

23. Above the assistant medical officer is the senior medical officer, who is in charge of one or more departments, such as those of school health, mental health, and maternity and child welfare. Such appointments are now made only where the local authority covers a population exceeding 250,000.

24. In certain large local health authorities the health services, including the school health service, are administered in geographical divisions, the medical officer in charge of the division being known as the divisional medical officer.

25. All these officers work under the general direction of the medical officer of health, who in the larger authorities is assisted in his multifarious administrative duties by a deputy medical officer of health.

26. There are certain other appointments, known as "combined appointments" and "mixed appointments," to which special salary arrangements apply. To describe these in detail would complicate this document unnecessarily, the aim being to present a clear picture of the general staffing structure, which is constituted by the grades mentioned above—medical officer of health, deputy medical officer of health, divisional medical officer, senior medical officer, and assistant medical officer.

The Present Salary Structure

27. Standardized salaries for public health doctors in England and Wales were first negotiated in 1929 at conferences, under the Chairmanship of Lord Askwith, which were held at the Ministry of Health and attended by representatives of the Local Authority Associations and the British Medical Association. The Askwith agreement made provision, in the cases of the medical officer of health and the deputy medical officer of health, only for minimum commencing salaries, varying according to the population covered by the authority. Scales of periodic increments were not formulated; it was understood that suitable increases would be given for capability and length of service. Incremental scales were agreed for senior medical officers and assistant medical officers. The Askwith agreement did not operate in Scotland, but the Association recommended salary scales on similar levels which were accepted by most of the Scottish Local Authorities.

28. In an interim revision of the Askwith agreement in 1946, percentage additions, varying in amount at the different levels, were made to the 1929 salaries, and a further interim revision was agreed with effect from 1st July, 1947.

29. When rates of remuneration, acceptable to the profession, were laid down by the Spens Committees for general practitioners and hospital doctors working in the National Health Service, it was clearly necessary to secure reasonably comparable standards of payment for the other main sections of the profession. The Staff Side of Committee C of the Medical Whitley Council, which is appointed by the Public Health Committee of the British Medical Association, eventually proposed to the Management Side new salary arrangements in which it had sought to apply what may be called the "Spens" standards to the remuneration of the public health doctors. The two Sides failed to agree and the matter was referred by mutual consent to arbitration in the Industrial Court. The decision of the Court (in December, 1950) was a disappointing one. The salaries awarded, although in some respects a little more generous than those which the Management Side had offered, fell far short of those which the Staff Side had claimed.

30. The Industrial Court, while retaining population as the criterion in determining the salaries of medical officers of health, adopted a proposal of the Management Side that a range of minimum salaries should be laid down for each population group. Each local authority was thus allowed a measure of discretion in fixing the commencing salary within the prescribed range, having regard not only to population but also to "other local factors and the functional responsibility of their medical officer of health post." The Court also specified the numbers and amounts of the annual increments to be granted, concerning which the authorities had enjoyed unfettered discretion under the Askwith agreement. Authorities with populations exceeding 600,000, however, were given complete discretion in determining both the commencing salary of the medical officer of health and the increments.

31. In 1953, after a further dispute in Committee C, the Industrial Court awarded a somewhat higher salary scale for assistant medical officers. In 1955, Committee C having again failed to agree, a further award was made by the Court. In this award, which covered all the salary scales, the Court granted the increases which had been offered by the Management Side, and the result again caused much disappointment to the Staff Side. Finally, in 1956, Committee C agreed on small percentage additions to the various scales. The new scales had effect from 1st April, 1956, and remain in operation to-day. They are set out in Appendix A.

Defects of the Present System

32. The first and most obvious defect of the present system of remuneration is that the salaries at all levels are too low, considered in relation to the net incomes earned in other branches of the profession. For example, the maximum salary of the assistant medical officer (£1,475) and even of the senior medical officer (£1,955) is far below the maximum (£2,350) for the medical officer in the most junior grade in the Civil Service—who, unlike the public health medical officer, suffers no deduction for superannuation. Towards the other end of the scale, the few medical officers of health (not more than a dozen) of authorities with populations between 400,000 and 600,000—the largest population group for which salaries have been prescribed—cannot receive, even if granted the highest salary within the permitted range, a maximum above £3,390, whereas hospital consultants in receipt of the lowest distinction award (20 per cent of all consultants in the Health Service) advance to a maximum of £3,600. Even among the very large authorities, which determine the salaries of their chief medical officers at their own discretion, there is no medical officer whose remuneration approaches the figure of £5,300—the maximum paid to the whole-time hospital consultants who receive the highest distinction award. The salary attached to the vastly responsible position of medical officer of health for London falls short of this figure by approximately £1,200.

33. The most formidable obstacle that the Staff Side of Committee C of the Medical Whitley Council has encountered is the rooted objection of the Management Side to approving salaries for medical officers of health different from those paid to other chief officers of local authorities. The Industrial Court, although it has not invariably awarded salary scales for medical officers in all respects identical with

those of the non-medical officers, has shown a marked reluctance to depart from these latter scales so far as the maximum salaries are concerned. The Staff Side of Committee C, on the other hand, holds firmly to the view that if the standard of recruitment to the public health medical service is to be safeguarded, the public health doctor must be regarded primarily as a doctor and must receive remuneration reasonably related to that received in other spheres of medical practice.

34. The Council of the British Medical Association, in a report published in 1956, made its attitude quite clear in the following statement: "The Council has kept continuously in mind and wishes here to emphasize the major principle that doctors, in whatever form of practice or service they are engaged, should be remunerated as doctors and that their remuneration should not be related to that of lay personnel who are employed in the same sphere. It is because of the attempted equation of medical officers with the hierarchy of local government officials that the situation in the public health service is so unsatisfactory."

35. The problem, however, would not be solved merely by a substantial increase in the present salaries of public health doctors at all levels. Not only are the amounts of the incomes earned in public health practice too low; but because of the relatively small proportion of intermediate posts the opportunities for promotion are unsatisfactory in the extreme.

36. A survey made two years ago of the comprehensive, if not completely exhaustive, information contained in the Association's register of public health medical officers showed that the assistant medical officers outnumbered all the other medical officers taken together, and that those in the intermediate grades between the assistant medical officer and the medical officer of health were relatively few. There were 646 medical officers of health, but only 140 deputy medical officers of health, only 16 divisional medical officers, and only 38 senior medical officers. The assistant medical officers numbered 1,300, and there were about 100 doctors in special posts, such as local authorities have discretion to create when necessary, with salary scales between those of the assistant and the senior medical officer or between those of the senior medical officer and the deputy medical officer of health. As the Council of the Association stated in the report referred to in paragraph 34 above, there was "a quite disproportionate number at the lower levels of remuneration" and the prospects of promotion to the senior posts were "significantly lower" than in any of the other branches of the profession.

37. In short, what is needed is not merely a general (and generous) increase in the present salary scales, but a reform of the career structure by the creation of many more intermediate posts of progressively increasing responsibility through which the public health doctor may climb on his way to one of the most senior appointments, and in which he will have a reasonable competence if there should be no room for him at the higher levels. The Association's proposals are set out in Appendix B.

38. Because of the urgent need for reform, the Association urged the Ministry of Health in 1956 to set up an independent committee of inquiry "to consider what should be the range of remuneration of medical officers in the public health service, having regard to the remuneration of other sections of the profession and the desirability of the public health service maintaining its power to attract a suitable type of recruit." When the Royal Commission was appointed the Prime Minister announced that consideration was being given to the inclusion of the public health doctors within their terms of reference. This seems to show that, in the opinion of the Government, there was no fundamental objection to the Commission being asked to recommend appropriate salaries for these doctors. Although the Association ultimately decided that the extremely disappointing exclusion of the public health doctors in the interpretation placed on the Commission's terms of reference was not a sufficient reason for refusing to state a case to the Commission on behalf of the family and the hospital doctors, it deeply deplores the Government's neglect of the opportunity of securing independent advice on a problem of vital importance to the nation. *It hopes that the Commission may see fit to recommend the institution by the Government of an independent inquiry in the event of continued failure to bring about a reform of public health medical remuneration through the established negotiating machinery.*

MEDICAL TEACHERS AND RESEARCH WORKERS

39. This important category includes more than 2,000 doctors in three main classes of employment:

1. University teachers in clinical subjects;
2. University teachers in pre-clinical subjects;
3. Whole-time research workers.

Many of those in category 1, and a few of those in category 2, hold honorary contracts in the National Health Service.

(1) University Teachers in Clinical Subjects

40. A university teacher frequently holds an honorary contract carrying consultant status with the National Health Service and frequently performs the same work with the same degree of responsibility as his colleague in the National Health Service. In the university he may be a professor, reader, or senior lecturer. He is usually a whole-time officer. He is expected to carry out his National Health Service duties as well as to prosecute research and to teach. Nevertheless, it is only at the professorial level that he approaches his National Health Service colleague in salary.

41. Even the reader or senior lecturer has a maximum of only £2,550 (with a possible £2,900 in exceptional circumstances, e.g., as head of a department), and this compares unfavourably with the remuneration* of his consultant colleagues in the National Health Service. The reader or senior lecturer has increments of £100 per annum, which also compares unfavourably with the increments on the consultant scale.

42. The practical effect of these lower scales of remuneration can be illustrated in *Pathology*. In many teaching hospitals, both in England and Scotland, much, if not all, of the pathology is carried out by university employees who may or may not have honorary contracts with the National Health Service, the Hospital Board usually contributing to the total costs. This results in the university staffs providing a service at a much lower rate. This anomaly is particularly noticeable in some areas of Scotland, where the pathological services of a whole region are obtained at university rates of salary. Similar circumstances obtain in all other clinical subjects within the university service.

43. Only the holders of honorary consultant contracts are eligible to be considered for *distinction award*, the proportion of the award payable depending on the amount of time spent on National Health Service work.

44. Reference is sometimes made to the supposed advantages of university teaching and research appointments—such as, vacations, time for research, freedom from the commitments of clinical practice, study leave, family allowances, etc., but when examined these advantages are more apparent than real:

Vacations. The university clinical teacher and the whole-time research worker outside the university are subject to similar restrictions in regard to vacations as is the consultant in the National Health Service.

Time for Research. Pressure of routine work for the National Health Service together with teaching duties may mean that time for research is hard to find.

Freedom from the Commitments of Clinical Practice. The university teacher with clinical responsibilities has the same liability to attend hospital at all hours as has his National Health Service colleague and has a continuous responsibility for his patients. This is obvious in the case of the physician or surgeon, but it is equally true, for example, of the pathologist concerned with blood transfusion or of the biochemist.

* Note.—The basic salary scale of consultants in the N.H.S. is £2,100 × £125 (8) to £3,100.

Study Leave. This is stated to be easier to obtain in university posts, but although most universities subscribe to the principle of sabbatical leave it is usual for this to go by default because no suitable deputy is available.

Family Allowances. Since these are payable at the rate of only £50 per child they cannot, except in the case of a large family, compensate for the difference in salaries. Moreover, they are taxable but are not added to the total remuneration for superannuation purposes. At the highest level of professorial salaries, these allowances are not paid if a distinction award is held.

(2) University Teachers in Pre-clinical Subjects

45. University teachers in the pre-clinical subjects usually have no honorary contract with the National Health Service, and thus are not eligible for merit awards. Their remuneration is usually less than that of the university clinical teachers by about 10 per cent. The recent University Grants Committee scales limit the salaries of professors to a maximum of £3,000 and, when it is recalled that the remuneration of a professor in a *clinical* subject, by the addition of a merit award, may be almost double that amount, there is little inducement to the best type of young graduate who intends to teach or do research to enter the pre-clinical field.

46. This is a matter of great anxiety to all who are concerned with recruitment to the pre-clinical subjects and has led to much understaffing and to the replacement of medically qualified staff by others with no medical qualification.

47. Although the pre-clinical teacher has no commitments with the National Health Service the advantages with regard to vacations and time for research are again more apparent than real. With the difficulty in recruitment departments are understaffed, so that teaching commitments are heavy. Vacation time is used to prosecute research, but here also there is difficulty, because of a shortage of technical assistance. This shortage is due to the higher wages obtainable by technicians in commerce and in the National Health Service. It leads to much waste of medical professional time.

(3) Whole-time Research Workers

48. Doctors in full-time research work, many of whom are employed by the Medical Research Council, have salary scales which are generally related to the university scales for equivalent seniority. Some of these research workers have clinical duties, but usually there is no contract with the National Health Service so that merit awards are not payable.

49. *Superannuation* is under the Federated Superannuation Scheme for Universities. With the continually falling values of money this scheme, which depends entirely on insurance policies to provide an annuity, is unfavourable when compared with a scheme which provides a pension based on salary at retirement. The inability to transfer pension rights freely as between the National Health Service and the Federated Superannuation Scheme for Universities, hampers a free flow from one service to the other.

50. *Income-tax.* University and research personnel are full-time employees, and as a result are at a disadvantage in relation to claims for such expenses as membership of learned societies, etc. The university clinician, for example, needs to have a telephone, to run a car, and to attend scientific meetings, but these items are not chargeable to expenses for tax purposes.

51. To enable the universities to continue to provide a high standard of medical education and to ensure that the research done in this country continues to be of a high standard, it is imperative that recruitment to university and research posts should be encouraged. This will only be so if the total eventual remuneration is such that it compares not unfavourably with that obtainable in the consultant and specialist branches of the profession.

52. The following scales are recommended for medical teachers and research workers in clinical subjects:

Senior lecturers and readers and corresponding grades of research workers

£2,700 × £162 10s.—£4,000, commencing salary to be determined by age (due regard being given to experience), the minimum of the scale being linked to age 32

Lecturers and corresponding grades of research workers

£1,600 × £125—£2,600

Junior lecturers, assistant lecturers, or demonstrators (i.e., the initial appointment on the academic staff), and corresponding grades of research workers

£1,100 × £100—£1,400. The commencing salary assumes an age of entry of 26 or 27 years. Appointments made at a lower age would carry a reduced salary

53. The present salary scales recommended by the University Grants Committee range from £900—£2,550 per annum (or in the case of lecturers holding posts of special responsibility, such as the headship of an independent department, £2,900 per annum). *The actual salaries paid are nevertheless at the discretion of the universities and may be, and indeed in some cases are, less favourable than the U.G.C. rates.*

54. It is also recommended that when machinery for reviewing the profession's remuneration at regular intervals in the future is established and adjustments are made in the remuneration of hospital medical staffs, corresponding adjustments should be made in the remuneration of university medical teachers and research workers in clinical subjects.

MEDICAL OFFICERS IN THE ARMED FORCES

55. Ever since 1948, the Council has been concerned at the low rates of pay of medical officers in the Armed Forces. Repeated representations have been made to the Defence Departments, and when the Forces Medical and Dental Services Committee (the Waverley Committee) was appointed by the Government in 1953, the Association took great pains to prepare and present evidence, both written and oral, to it.

56. The recommendations of the Waverley Committee were published in 1956. These recommendations were regarded by the Council as highly unsatisfactory, and repeated representations have been made to the Ministry of Defence about them.

57. In 1958 improvements in remuneration were introduced in the Armed Forces, but, with a few exceptions, the current rates for medical officers are not as high as those which were suggested by the B.M.A. to the Waverley Committee in 1954.

58. The recruitment position in the regular Armed Forces reflects the unsatisfactory state of medical remuneration.

THE SUPPLEMENTARY OPHTHALMIC SERVICE

Description

59. Section 41 of the National Health Service Act, 1946, and the Regulations made under that section prescribe the duties and functions of local executive councils with regard to the Supplementary Ophthalmic Service.

60. Broadly speaking it is the duty of every executive council to make arrangements with doctors having prescribed ophthalmic qualifications (called "ophthalmic medical practitioners"), and with ophthalmic opticians for the testing of sight, and with ophthalmic opticians and dispensing opticians for the supply or replacement and repair of glasses.

61. A person wishing to use the Supplementary Ophthalmic Service has two separate choices. First, he has the right to choose the ophthalmic medical practitioner

or ophthalmic optician by whom his sight is to be tested and from whom any necessary prescription for glasses is to be obtained; and, secondly, he has the right to choose the ophthalmic or dispensing optician who is to supply his glasses.

62. For children under 16, and for persons who because of old age, illness, or other infirmity cannot choose for themselves, a parent, guardian, or other person in charge, exercises these choices.

63. It is also an important principle of the service that an applicant must produce a medical recommendation on the first occasion upon which he wishes to have his sight tested under the service. A medical recommendation is, however, not required on any subsequent application for the service. For further sight tests, the applicant is free to go direct to the ophthalmic medical practitioner or ophthalmic optician of his choice.

Continuation of the Service

64. Section 41 (4) of the Act states that "where the Minister is satisfied that adequate ophthalmic services are available in the area of any executive council through the hospital and specialist services provided under Part II of this Act, he may by order direct that this section shall cease to apply to that area, and this section shall thereupon cease to apply as from a date specified in the order; and any such order may contain such consequential and incidental provisions as the Minister considers necessary or expedient.

65. Although this section of the Act has never been amended it seems clear from official pronouncements on the subject, and, in particular the findings of the Guillebaud Committee, that the Supplementary Ophthalmic Service is likely to continue for a very long time to come. It is therefore necessary to say something about the ophthalmic medical practitioner, who plays an important part in this Service. Up to the present some 1,260 ophthalmic medical practitioners have satisfied the criteria laid down by the Ophthalmic Qualifications Committee. The criteria were last revised in 1951, since when they have been as follows:

A medical practitioner must have

- (a) held an appointment under the Hospital and Specialist Services provided under Part II of the Act with the status of consultant ophthalmologist or held for a period of two years an appointment of equivalent status as an ophthalmic surgeon or assistant ophthalmic surgeon on the staff of an ophthalmic hospital or a hospital having a special ophthalmic department approved for this purpose by the Committee; or
- (b) obtained the Diploma in Ophthalmic Medicine and Surgery or the Diploma in Ophthalmology (Conjoint Board) or the Diploma in Ophthalmology (Oxon) or other higher degree or qualification approved by the Committee and held for a period of two years an appointment or appointments in an ophthalmic hospital or the ophthalmic department of a general hospital which has been approved by the Committee for this purpose of which period at least six months shall have been spent in a resident appointment, or in an appointment with duties similar to those in a resident appointment,

AND WHO SHALL, TO THE SATISFACTION OF THE MINISTER ACTING ON THE ADVICE OF A COMMITTEE TO BE RECOGNIZED BY HIM FOR THE PURPOSE OF APPROVING SUCH QUALIFICATIONS (i.e., the Ophthalmic Qualifications Committee), HAVE HAD ADEQUATE, INCLUDING RECENT, EXPERIENCE.

66. It is thus clear that an ophthalmic medical practitioner must not only be a qualified medical practitioner but since 1951 he must also possess a higher qualification in ophthalmology and have had considerable practical experience in the specialty before he can take part in the Supplementary Ophthalmic Service. Indeed, as will be shown later in this memorandum, the Ministry of Health recognised the special qualifications, training, and experience of ophthalmic medical practitioners when it decided to relate the amount of the sight-testing fee to the remuneration enjoyed by S.H.M.O.s and consultants in the Hospital Service.

The Sight-testing Fee

67. In 1948 at the commencement of the Service the sight-testing fee was £1 11s. 6d., based on the assumption that the average time taken for a sight test was thirty minutes. In April, 1949, the Ministry quite arbitrarily cut the fee to 25s. on the basis that enquiries had tended to show that sight testing was being undertaken in less than thirty minutes. The Ministry indicated that 25s. would be a provisional figure (based on 24 minutes) pending a fact-finding enquiry into the average time per sight test. *The Ministry promised that if investigations revealed that the reduction was not fully justified an appropriate adjustment would be made.*

68. The Penman Working Party, which was then set up, found by means of a sample investigation that the average time taken for a sight test was 25.2 minutes, but that certain adjustments ought to be made, the effect of which increased the length of the average sight test by 2.2 minutes to 27.4 minutes.

69. The Ministry accepted the Penman figure of 25.2 minutes and certain of the adjustments. The figure eventually taken was 27.1 minutes. A copy of the Penman Report is attached as Appendix C.

70. The Association therefore sought an adjustment in the fee as a result of the Working Party's finding and in the light of the undertaking previously given by the Ministry that the fee would be adjusted should it be shown that the reduction made in 1949 was not justified. The adjustment required was an additional 3s. 3d. for the extra 3.1 minutes (i.e., instead of 25s. 0d. for 24 minutes, 28s. 3d. for 27.1 minutes).

71. The Ministry, however, took the view that the whole question of the fee must be considered "against the wider background of a re-examination of the original basis on which the fee was fixed."

72. The Ministry maintained that when the original fee had been fixed the remuneration for hospital medical staff had not been finally decided, and the fee had been based on a possible hourly rate for consultants of three guineas. The basic consultant scale (then £1,700-£2,750) which was subsequently introduced gave a considerably lower hourly rate, and the Ministry therefore took the view that the original sight-testing fee had been wrong not only as regards the time taken but also in its relation to comparable remuneration in the Hospital Service.

73. In January, 1951, the Association discussed this proposal with the Ministry and suggested that the following factors should be taken into consideration:

- (a) The findings of the Working Party, in the light of which the average time taken to test sight by an ophthalmic medical practitioner had been accepted as 27.1 minutes.
- (b) The Minister's undertaking in a letter of 14th February, 1949, to make an appropriate adjustment in the fee if the original reduction was shown not to have been fully justified.
- (c) The clinical qualifications and status of the practitioners engaged in the Supplementary Eye Service and the standards observed and proposed to be observed by the Central Professional Committee.
- (d) The level of remuneration of officers with comparable clinical responsibilities in the Hospital Eye Service.

74. After a lengthy exchange of views, however, the Ministry firmly refused to adopt any more favourable basis for calculating the sight-testing fee than the mid-point (£2,025) between the bottom of the then S.H.M.O. scale (£1,300) and the top of the then basic consultant scale (£2,750).

75. Having decided that the comparable figure in the Hospital Service was £2,025, the Ministry then made adjustments for practice expenses (33½ per cent) and superannuation (8 per cent) and calculated a figure of 16s. 6d. To this was added 3s. 3d. "to compensate for the difference in time as shown by the Penman Report." This 3s. 3d. represented the difference between the provisionally reduced fee of

25s. (based on 24 minutes) and 28s. 3d. (based on 27.1 minutes), which would have been the fee if the Penman Report and no other factors had been taken into consideration.

76. The following figures show, in more detail, how the calculation was made:
 $\pounds 2,025$ plus $33\frac{1}{2}$ per cent for practice expenses plus 8 per cent for superannuation = $\pounds 2,862$.

$\pounds 2,862$ divided by $3,465 = 16s. 5\frac{1}{2}d.$ (approx.).

($3,465$ is the number of half-hours in a year of 45 weeks each of $38\frac{1}{2}$ hours ... $11 \times 3\frac{1}{2}$.)

77. The resulting figure of 19s. 9d. (16s. 6d. plus 3s. 3d.) was then rounded off to $\pounds 1$.

78. A formal offer of $\pounds 1$ was subsequently communicated to the Association by the Ministry.

79. The Association after careful consideration, taking into account reports of regional meetings of ophthalmic medical practitioners, informed the Ministry that it was unable to recommend acceptance of the offer by the profession.

80. *In spite of the Association's protests the fee of $\pounds 1$ was nevertheless brought into operation by the Ministry and took effect from 14th February, 1951.*

81. In 1954 following the adjustment in the remuneration of hospital medical staff, further representations were made by the Association to the Ministry for a corresponding adjustment in the amount of the sight-testing fee.

82. It was pointed out that under the new scales for hospital medical staff the mid-point between the minimum of the S.H.M.O. scale ($\pounds 1,500$) and the maximum of the consultant scale ($\pounds 3,100$) became $\pounds 2,300$, and that therefore even on the basis of the Ministry's own calculation as set out above the sight-testing fee should be increased to 22s.

83. In spite of personal representations to the then Minister of Health, the Government would not agree to any increase in the fee, which remained at $\pounds 1$, a figure far less than the $\pounds 1$ 11s. 6d. deemed appropriate in 1948. Today, following the interim adjustment made to general practitioners and hospital medical staffs pending the report of the Royal Commission, the figure stands at $\pounds 1$ 0s. 8d. The Government instruction authorising this small interim increase is set out in Appendix D.

84. The Council submits that the history of the negotiations with the Ministry on the size of the sight-testing fee is yet another example of the Government's reluctance to give effect to agreements which it made with the profession before the inception of the National Health Service.

85. It may be that ophthalmic medical practitioners are a minority group within the profession, but the fact remains *that they are the only section whose remuneration today is substantially below the level fixed nearly ten years ago*. There is perhaps little wonder that this record of negotiation and the inadequate levels of remuneration are not attracting the proper proportion of recruits to this important branch of the Service.

86. It must be stressed that the Ministry in 1951 and again in 1957 agreed that, in fixing the size of the sight-testing fee, regard should be paid, *inter alia*, to (a) the clinical qualifications and status of the practitioners engaged in the Supplementary Eye Service and the standard observed and proposed to be observed by the Central Professional Committee in approving qualifications; (b) the level of remuneration of officers with comparable clinical responsibilities in the Hospital Eye Service.

87. Whereas the clinical qualifications and status of the practitioner engaged in the Supplementary Ophthalmic Service have not changed, hospital medical staffs have already had one increase (in 1954) and their remuneration is now the subject

of a substantial claim which has already been submitted to the Royal Commission. Moreover, the impact of the cost of living falls no less on ophthalmic medical practitioners than on other sections of the profession, and the Council submits that their claim on behalf of ophthalmic medical practitioners should be no less than that claimed for other sections of the profession.

88. The ophthalmic medical practitioner has continued to give loyal service to the community under very adverse terms of service, and the Council submits that the sight-testing fee should now be increased in direct proportion to any increase recommended for hospital medical staff with comparable clinical responsibility in the Hospital Eye Service.

89. The Council submits that in all justice to this section of the profession even if the £1 sight-testing fee were taken as the basis (and it has never been accepted as valid by the Association) there is need for a twofold increase in the sight-testing fee. First a retrospective increase to 22s. 0d. to bring the fee into line with the 1954 Award to the hospital medical staff, upon whose salaries the fee was based. Second the fee augmented in that way requires to be increased by not less than 29 per cent in accordance with the claim submitted on behalf of general practitioners and hospital medical staffs and which is set out in full in the Council's Preliminary Memorandum of Evidence to the Royal Commission.

APPENDIX A

PRESENT REMUNERATION OF PUBLIC HEALTH MEDICAL OFFICERS (March, 1958)

Medical Officers of Health

<i>Population Group</i>	<i>Commencing salary</i>		<i>Increment</i>	
<i>Not exceeding</i>	<i>Between</i>			
75,000	£1,740 and	£1,955	4 × £55;	
100,000	£1,850 "	£2,175	4 × £55; 1 × £50	
150,000	£2,070 "	£2,395	4 × £55; 1 × £50	
250,000	£2,290 "	£2,605	2 × £105; 1 × £55	
400,000	£2,550 "	£2,865	2 × £105; 1 × £55	
600,000	£2,655 "	£3,075	3 × £105	
Over 600,000 ...	At discretion	... ..	At discretion	

Each local authority has first to determine, within the limits set out above, the appropriate scale for its medical officer of health post, having regard to its population, other local factors, and the functional responsibility of the post. A medical officer of health who is aggrieved by the decision of his authority may appeal formally under the Whitley Appeals Machinery for a higher scale within the range. It is open to a local authority to pay its medical officer of health a personal salary above the scale which it has selected as appropriate for the appointment and which would be offered if a successor were being appointed.

A medical officer of health holding combined appointments receives £100 per annum above the appropriate salary scale indicated by the total population of the combined districts for which he is medical officer of health.

Part-time medical officers of health are remunerated in accordance with the Spear formula in respect of consultants.

Deputy Medical Officers of Health

Medical officers duly appointed as deputy medical officers of health in the general administration of the public health service and the carrying out of the various Acts, By-laws, Orders, Rules, Regulations, etc., required to be or usually administered by the medical officer of health receive a commencing salary which is 6½ per cent of the minimum of the scale adopted by the employing authority for its medical officer of health post, with annual increments of the same number and amount as those of the scale for the medical officer of health post.

It is recognised that an authority with a population below 75,000 should not normally need the services of a whole-time deputy medical officer of health, but it is agreed that, where such an authority finds it necessary to appoint a deputy, he may receive a personal salary of not more than £50 above that of an assistant medical officer colleague whose salary would otherwise have been equal to or greater than the deputy's salary.

Divisional Medical Officers

Medical officers, not acting as county district medical officers of health, duly appointed as divisional or area medical officers for divisional administration of the Health Services (including the school health service) receive the salary scale for senior medical officers, with the following additions according to the population of the division:

						£
Not exceeding 150,000	...	...	...	...	...	50
" " 250,000	...	...	...	...	...	150
" " 400,000	...	...	...	...	...	250
Over 400,000	...	...	...	...	...	At discretion

Senior Medical Officers

These are medical officers (not being medical officers of health) who are in charge of services or departments (for example, port health, school health, mental health, maternity and child welfare, or any other similar service or combination thereof), and who are engaged solely or mainly on such duties. New appointments in this grade are limited to authorities with populations exceeding £250,000.

Scale: £1,520 × £50—£1,570 × £55—£1,955

Assistant Medical Officers or Medical Officers in Departments

Scale: £1,050 × £50—£1,200 × £55—£1,475

Other Grades

Individual authorities which find it necessary to make provision for posts between the grades of assistant medical officer and senior medical officer and/or for posts between the grades of senior medical officer and deputy medical officer of health have discretion to select the titles for such posts and the appropriate salary scales.

Mixed Appointments

Medical officers who are assistant medical officers or divisional or area medical officers under a county council, acting as district medical officers of health (either for single or combined districts) for a definite proportion of their time, receive as regards the salary for their county council work the appropriate proportion (calculated in accordance with the Spens formula) of their salary as assistant, divisional, or area medical officers, as the case may be, together with the appropriate proportion of the salary selected from the appropriate range for county district medical officers of health, plus a similar proportion of £100.

These arrangements apply also to:

- (i) Assistant medical officers or area or divisional medical officers or deputy divisional medical officers under a County Council, acting as deputy district medical officers of health.
- (ii) Deputy county medical officers of health, acting as district medical officers of health.
- (iii) Deputy county medical officers of health, acting as deputy district medical officers of health.

APPENDIX B

PROPOSED REFORMS (March, 1958)

1. The Association's proposals for reform are shown in the revised salary scales set out below. The main features of the suggested new scheme are a general increase in remuneration and a multiplication of the steps on the ladder of promotion from the most junior to the most senior appointments. As has been mentioned, local authorities may make provision, when necessary, for posts at a higher level than that of the assistant medical officer but not appropriately placed in the category of senior medical officer, and may determine the salary scales for such posts at their discretion. It is now suggested that an intermediate grade of this kind should be recognised with the title of senior assistant medical officer and a nationally agreed salary scale. Five grades of senior medical officer are now recommended. It is proposed that the remuneration of divisional medical officers should not, as at present, be related directly to the remuneration of senior medical officers. It is recommended that the salaries of divisional medical officers, who are appointed by local health authorities for divisional administration of the personal health services, should be related to the salary scales for medical officers of health of local health authorities. It is also recommended that the complete discretion allowed at present in the determination of the salaries of medical officers of health of the very large authorities should be abolished and that salary scales should be laid down for three population groups above 600,000, a single scale—not a range of scales—being fixed for the very small number of posts where the population exceeds two million.

2. Finally, it is recommended that a London weighting of £100 should be added to the salaries of medical officers employed by the London County Council in the grades of medical officer in department (assistant medical officer) and senior assistant medical officer.

Proposed Remuneration of Public Health Medical Officers

Medical Officers of Health

Population Range		Range of Commencing Salaries			Increments
Under 75,000	...	£2,205-£2,505	...	...	3 × £100
75,000- 100,000	...	£2,400-£2,700	...	...	3 × £100
100,000- 150,000	...	£2,600-£3,100	...	...	3 × £100
150,000- 250,000	...	£2,800-£3,400	...	...	3 × £100
250,000- 400,000	...	£3,000-£3,700	...	...	3 × £100
400,000- 600,000	...	£3,200-£4,000	...	...	3 × £100
600,000-1,000,000	...	£4,000-£4,300	...	...	3 × £150
1,000,000-2,000,000	...	£4,300-£4,600	...	...	3 × £150
Salary Scale					
Over 2,000,000	...	£4,755 × £150 (2) × £200 (2) to £5,455			

(With the exception of the few authorities with populations exceeding two million, each authority shall be required to determine the appropriate salary scale within the range for its medical officer of health appointment, having regard to its population, other local factors, and the functional responsibility of the medical officer of health post. In the case of a local health authority* with a population below 600,000, the salary scale for its medical officer of health appointment shall not in any circumstances commence at a point lower than the mid-point of the range of commencing salaries. As at present, appeals machinery shall exist under which a medical officer of health may appeal formally against the extent to which his authority has exercised its discretion in selecting the scale for his appointment. Further, it shall be open to an authority to grant its medical officer of health a personal salary above the agreed

* The local authorities designated as Local Health Authorities are, in England and Wales, the County and County Borough Councils, and, in Scotland, the County Councils and the Councils of the Counties of Cities and the large Burghs.

salary for the appointment, in which case the salary for the deputy medical officer of health will be related to the salary for the medical officer of health post and not to the personal salary granted to its holder. Moreover, a local authority shall review the salary of its medical officer of health, whether this be the salary selected for the appointment or a personal salary at a higher level, not later than five years after the medical officer of health has reached the maximum of his salary scale, and thereafter at intervals not exceeding five years, and shall have discretion to grant, in recognition of attainments and length of service, a higher salary which may exceed the maximum prescribed in the above scales.)

Deputy Medical Officers of Health

The minimum of the scale for a whole-time deputy medical officer of health shall be 66½ per cent of the minimum of the scale for the post of medical officer of health of the same authority, and the annual increments shall be the same as those for the post of medical officer of health.

The existing special arrangements for the remuneration of deputy medical officers of health of authorities with populations below 75,000 shall continue.

Divisional Medical Officers

(Medical officers appointed by local health authorities for divisional administration of the health services—including the school health service.)

These medical officers shall receive a commencing salary not less than 80 per cent of the minimum commencing salary for a medical officer of health of a local health authority with a population of the same size as their division. The appropriate commencing salary, which shall be within a range extending to 80 per cent of the maximum commencing salary for a medical officer of health of a local health authority of the same size, shall be determined with regard to the population of the division, other local factors, and the functional responsibility of the divisional medical officer post. As in the case of medical officers of health, a divisional medical officer shall have the right to appeal formally against the extent to which his authority has exercised its discretion in selecting the scale for his appointment. A divisional medical officer shall receive annual increments of the same number and amount as a medical officer of health of a local health authority of the same size as his division.

Senior Medical Officers

(Medical officers (not being medical officers of health) who are in charge of services or sections of health departments (for example, port health, school health, mental health, maternity and child welfare, or any other similar service or combination thereof), and who are engaged solely or mainly on such duties.)

Grade I	(Appointments under authorities with populations between 150,000 and 250,000) ...	£1,800 × £75 to £2,250
" II	(Appointments under authorities with populations between 250,000 and 400,000) ...	£2,000 × £75 to £2,450
" III	(Appointments under authorities with populations between 400,000 and 600,000) ...	£2,200 × £75 to £2,650
" IV	(Appointments under authorities with populations between 600,000 and 1,000,000) ...	£2,600 × £75 to £3,050
" V	(Appointments under authorities with populations exceeding 1,000,000) ...	£2,800 × £75 to £3,250

Senior Assistant Medical Officers

(Medical officers with additional qualifications or exceptional experience, and accepting additional responsibilities or carrying out additional duties which do not amount to being in charge of a department as a senior medical officer.)

£1,700 × £75–£2,000

Assistant Medical Officers or Medical Officers in Departments

£1,150 × £75-£1,825

(A local authority shall have discretion to take into account any additional qualifications or special experience which a medical officer may have in determining his commencing salary on the above scale.)

Note.—The above salary scales for public health medical officers have been worked out in relation to the remuneration of other sections of the medical profession as it exists in March, 1958.

Medical Officers of the London County Council

Medical officers of the London County Council in the grade of medical officer in department (assistant medical officer) and in the grade of senior assistant medical officer shall receive an additional £100 "London weighting" on all points of the national scales for these grades.

Combined and Mixed Appointments

The existing arrangements for "weighting" the salaries of holders of combined and mixed appointments shall continue.

Part-time Medical Officers of Health

A medical officer who is engaged part-time in the public health service by virtue of holding a part-time M.O.H. appointment shall be remunerated in accordance with the Spens formula in respect of consultants.

Operative Date

The above scales shall be introduced with effect from 1st June, 1958.

Assimilation to the New Scales

Officers at present in post shall be assimilated to the above scales on the "corresponding points" principle, that is to say, each officer shall be placed on the point in the new scale which he would have reached had the scale been operative at the date of his appointment to his present post, but the operation of the new scales shall not in any circumstances result in a reduction in salary of any officer in post.

APPENDIX C**MINISTRY OF HEALTH AND DEPARTMENT OF HEALTH
FOR SCOTLAND**

**Report of the Working Party on the average time taken to test
sight by ophthalmic medical practitioners under the
Supplementary Ophthalmic Services of the
National Health Service in England,
Wales, and Scotland**

(Already published)

APPENDIX D

E.C.L. 48/57

MINISTRY OF HEALTH,
SAVILE ROW,
LONDON, W.1.

27th June, 1957.

SIR,

Supplementary Ophthalmic Services

Fees Payable to Ophthalmic Medical Practitioners

I am directed by the Minister of Health to state that he has had under consideration representations made by the Ophthalmic Group Committee of the British Medical Association that the fee of £1 payable by an Executive Council to an ophthalmic medical practitioner for the testing of sight under the Supplementary Ophthalmic Services should be increased having regard to the recent decision to make increases of 5 per cent in the salaries of consultants and senior hospital medical officers (with which the sight-testing fee is linked) and in the net remuneration of general medical practitioners. The sight-testing fee, payable to ophthalmic medical practitioners, includes an allowance of 33½ per cent for expenses, and the equivalent of the interim increase awarded to consultants and senior hospital medical officers would be represented by an increase of 8d. in the total sight-testing fee. After consulting the Ophthalmic Group Committee, the Minister has accordingly decided that this fee should be increased to £1 0s. 8d. as an interim measure pending, and without prejudice to, the Royal Commission's recommendations.

The Minister accordingly hereby amends item 1 of Part I of the Statement of Fees and Charges to read:

	£	s.	d.
"1. By an ophthalmic medical practitioner	1	0	8."

This increase takes place immediately and should be applied to all such fees paid on or after July 1.

The first account including this increase in remuneration paid to each ophthalmic medical practitioner should be accompanied by a note explaining that the increase of 8d. in the fees for a sight test is an interim measure associated with the decision to make increases of 5 per cent in the net remuneration of consultants, senior hospital medical officers, and general practitioners.

A copy of this circular letter is enclosed for the information of the Local Medical Committee.

The Clerk of the Executive Council
and the Ophthalmic Services Committee.

94259/3/16.

FOURTH SUPPLEMENTARY MEMORANDUM OF EVIDENCE

Presented by the British Medical Association to the Royal Commission on Doctors' and Dentists' Remuneration

INTRODUCTION

1. In its Preliminary Memorandum of Evidence the Council dealt with the general principles involved in its dispute with the Government and with its claim for an overall increase of not less than 29 per cent in the remuneration of both general practitioners and doctors in the hospital service. Subsequently, in its Second and Third Supplementary Memoranda of Evidence, sent to the Commission on 16th June, the Council put forward detailed proposals for the remuneration of all grades of hospital medical staffs. In this Fourth Supplementary Memorandum the Council deals with a number of questions on general practice which the Royal Commission itself posed in the course of oral evidence on 23rd and 24th January and emphasizes some other aspects of general practice which it considers should be brought to the notice of the Commission.

MATTERS UPON WHICH THE COMMISSION HAS INVITED THE ASSOCIATION TO SUBMIT FURTHER EVIDENCE

(1) **The Spens Recommendation for an Augmented Capitation Fee for an abnormal number of aged patients or chronic invalids (Recommendation 6)**

2. This recommendation has been carefully re-examined in the light of present circumstances and having regard to the practical considerations involved, if such a scheme is to operate fairly. First, it would be necessary, as far as the aged are concerned, to prescribe an arbitrary age limit. Secondly, it would be necessary to define precisely the term "chronic invalid," and this would necessitate the very difficult task of setting out a list of diseases or infirmities which vary widely in severity and chronicity. Thirdly, some formula would be necessary to determine the basic percentage of those in these categories on each doctor's list above which the augmented capitation fee would apply. The administrative difficulties involved are obvious. The fluctuations in doctors' lists would necessitate a continuous review and recalculation in the case of the vast majority of general practitioners who might qualify under any scheme of this kind.

3. The Council feels that such a scheme would be useful only if it could be shown that in the above categories there is considerable unevenness of distribution as between one practitioner and another.

4. For these reasons, and primarily because of the administrative difficulties, the Council does not feel that it would be possible to achieve a scheme of this nature which would work equitably in practice. Nevertheless, whilst it doubts whether any special action on these lines would be justified, it is always prepared to discuss the matter with the Ministry in the light of any evidence which would appear to justify a modification of the existing distribution scheme.

(2) **"Merit Awards" in General Practice**

5. During the course of oral evidence the Commission asked the Council's representatives to comment upon the possibility of introducing a scheme of merit awards in general practice. The suggestion is by no means new but hristles with difficulties. It has been considered by other bodies, including the Cohen Committee on General Practice, which made no recommendations on the subject.

6. It was also debated by the Representative Body of the Association at Birmingham in July of this year, when the following resolution was passed:

That this Meeting can see no objection to a "merit award" scheme for general practitioners, provided a practicable scheme can be devised and subsequently approved by the Representative Body.

7. The following paragraphs embody various criteria to each of which proper weighting should be given in the consideration of any scheme of this kind in general practice. The Council considers that the title of any award based on such criteria is important and it feels that "commendation" or some other term would be a more acceptable title than "merit."

1. To qualify at all a general practitioner would need a minimum period—for example, 10 years—in N.H.S. general practice with a minimum average list (the number varying according to the type and location of practice) over the period.
2. Due regard could be paid to post-registration hospital appointments.
3. Postgraduate clinical qualifications or diplomas approved for the purpose could be taken into account.
4. A further criterion could be evidence of "approved" postgraduate study.
5. Due weight could be given for special services and abilities not already taken into account under the previous headings.

8. The Council wishes to emphasize that these criteria are extremely tentative and there are many practical difficulties involved. Partnership agreements, for instance, frequently require earnings from all sources to be paid into the partnership's accounts and distributed in accordance with the partnership's shares. Again, general practitioners work under very different conditions from consultants and specialists, and although the criteria set out above are important the attachment of special weight to them will not necessarily identify the doctor who is worthy of special recognition.

9. The fundamental difficulty is to distinguish the doctor who is outstanding, and the nature of general practice is such that it is doubtful if any one person or body of persons can accurately assess the value of the services of the individual practitioner to the community. The Council is, in fact, in some doubt whether it is possible to devise any scheme of merit awards in general practice which the profession would accept as affording proper recognition, and it must emphasize that the profession's reaction cannot be anticipated until a detailed scheme is available for consideration.

(3) Assistants in General Practice

10. During the course of oral evidence the Council's representatives were invited to comment upon a number of points in connexion with the remuneration and terms of service of assistants in general practice.

11. First, the Council would like to place on record its view that an assistantship provides the best possible introduction to general practice. It enables the young practitioner whose experience of medical practice is confined to a hospital environment to gain an insight into the problems that arise in general practice and to acquire experience in the care of patients and the general administration of a form of practice which is quite different from his previous experience. The young doctor fresh from hospital has little knowledge of the sociological and legal aspects of general practice and may need to reorientate his views on prescribing for his patients. A period of assistantship provides such essential training and also affords both principal and assistant the opportunity of working together and deciding whether from all points of view both are desirous of making the introduction permanent by way of a partnership.

12. It has frequently been said that the advantages of an assistantship lie wholly with the principal. This is not so, for the assistant is gaining his experience in the practice of the principal who has the full responsibility for the practice. Whilst such a position is not peculiar to medicine, in general practice the principal's responsibility is specific, for under paragraph 8 (8) of his Terms of Service he is responsible for the acts and omissions of the assistant.

13. Again the principal must accept a reduction in net income until such time as the size of his list approaches the maximum allowed by virtue of the employment of an assistant.

14. Some assistants wish merely to have a trial period in general practice to see if they like it. Others want an opportunity to look around so that they can determine the type of practice they desire, and where they want to settle down.

15. A good deal of criticism has been directed against the employment of assistants without a view to partnership. There are circumstances in which the help of an assistant in a practice is necessary. Yet to take the assistant into the practice as a principal would not be in the best interests of the assistant. Indeed, the offer to do so would be misleading and lead to frustration in the future. For example, the principal may have a prolonged illness (such as tuberculosis), or he may be engaged in a long period of postgraduate study. There is also the situation in which the list of the principal just exceeds the permitted maximum. It cannot be known at this stage if the practice will continue to grow and support two principals. Again, a practice may have more than the permitted maximum number of patients, but the future is uncertain because of anticipated re-development in the area with a considerable reduction in population.

16. In all these examples some help is necessary to enable practice obligations to be carried out, and the Council believes that, providing the circumstances are made known in advance to the assistant and subject to the safeguards now in the hands of Executive Councils, such free association between principal and assistant is unobjectionable.

(4) Remuneration of Assistants

17. The Council has undertaken further enquiries into existing salary levels in this field and has endeavoured to ascertain the extent to which the salary of £500, recommended by the Spens Committee as being appropriate to the assistant's initial appointment, is being implemented.

18. After taking into account the Danckwerts betterment factor the figure would be £1,000, and allowing for a further 5 per cent increase in respect of the interim adjustment made in net remuneration on 1st May, 1957, the present-day figure would be approximately £1,050.

19. From the enquiries which it has made, the Council believes that present-day salaries, when combined with the emoluments which are attached to many posts, reach at least this figure and, in many cases, exceed it. In London, for instance, where a review of all assistants is taking place, of the first fifty-one whole-time assistants of principals interviewed during the period 1st January, 1957, to 1st April, 1958, the average gross remuneration at that time, including emoluments, was £1,245.

20. The car allowance in these cases averaged only £150, for in a number of instances no car was necessary. Thus the assistants concerned were on average receiving salaries well in excess of £1,050 even before 1st May, 1957.

21. The Council would at this stage like to acknowledge the help of the London Executive Council in making this information available.

22. These facts are in line with the experience of the Association's Medical Practices Advisory Bureau, where, since April, 1958, doctors requiring assistants have offered salaries and emoluments ranging from £1,100 to £1,400 per annum—the average being £1,260 per annum. Some further information prepared by the Medical Director of the Bureau on the position of assistants in general practice appears in Appendix A.

23. On a number of occasions in the past the Council has considered the possibility of laying down a standard minimum salary for assistants and of enforcing such a policy by restricting advertisements for assistants in the *British Medical Journal* to those which conform to that minimum.

24. There are, however, considerable difficulties. In the first place the *British Medical Journal* has no monopoly, and the rejection of an advertisement by the *Journal* does not exclude its publication elsewhere. Secondly, many assistantship agreements are concluded privately and without advertisement of any kind. These factors undoubtedly reduce the effectiveness of action on these lines.

25. In addition there are practical considerations. Not infrequently the cash salary which is advertised for a particular post carries additional emoluments such as a rent-free flat or house, or free board and lodging. The difficulties of assessing the value of emoluments in different circumstances will be obvious. Then again

the assistantship may not be full-time (the London enquiry, for example, showed that nearly 50 per cent were engaged for less than full-time) or may carry other advantages to the assistant which may not be disclosed in the advertisement. Indeed, even full-time posts can give rise to anomalies, for the term covers a widely differing range of duties and responsibilities. It is such questions as these which have led the Council to refrain from attempting to impose a minimum salary by such means in the past.

26. Such evidence as is available, however, indicates that, in general, the salaries now paid to assistants exceed the Spens figure revised in the light of increases in the remuneration of established general practitioners.

27. Remuneration apart, the Council takes the view that the regular review of assistantship arrangements now being undertaken locally by Executive Councils in consultation with Local Medical Committees as a result of suggestions already made by the Association in this field should prove the most effective check to such abuse of the assistant system as may exist. A full knowledge of all the circumstances of *both principal and assistant* is essential, and it is only at local level that the full facts of a particular case can be established.

28. The penalty of withdrawal of the right to employ an assistant or a reduction in the size of the additional list of patients allowed is likely to prove an effective deterrent to abuse.

(5) Practice Expenses

29. Several other bodies, in particular the Medical Practitioners' Union, in giving evidence to the Commission have criticized the present method of distributing practice expenses, and the suggestion has been made that these monies should be separated from the Central Pool and paid out independently by a method which, it is contended, would result in a more equitable reimbursement of the individual doctor.

30. In the Council's view, the present system, in spite of its defects, affords at least rough justice and protects both the profession and the Treasury. By viewing the varying expense ratios of different sizes and types of practice at one particular moment in time, which is the effect of the Inland Revenue enquiries, the picture is distorted, for no practice remains static during its lifetime. As in other professions, the newcomer building up a practice will expect to face relatively heavy expenses during his initial years, the ratio will gradually diminish as he becomes established and then rise again in later years as his list and the volume of work which he can undertake falls. The pattern of expenses, viewed over the lifetime of most general practitioners, is not dissimilar, and in the long run some approach to equality is achieved.

31. Special provision is already made for the new entrant who commences practice in an area where more doctors are needed, i.e., areas designated by the Medical Practices Committee, whilst at a later stage in the doctor's life when his list is below certain levels he may be eligible for other payments from the Pool such as a Supplementary Annual Payment or a Hardship Payment.

32. These and similar arrangements make a valuable contribution towards the expenses of the small-list doctor who is practising in an area where his services are needed by the community.

33. Whilst the actual amounts of these allowances may require review from time to time, the Council is convinced that this is the best method of meeting a difficult problem. The division of practice expenses into groups as is done in the Inland Revenue enquiries does not of itself provide an accurate picture, for even in these groups there will be considerable variation. From the Government's point of view, the present system provides an incentive for the individual doctor to exercise reasonable economy. First, all expenses are subject to scrutiny by the Inland Revenue, and although there is an element of choice, this fact in itself ensures that only such expenses are incurred as are likely to be accepted as valid. Secondly, whilst the profession as a whole is reimbursed its total expenses (although in part not until some eighteen months later), the individual doctor's share is not directly related to his own personal expenditure. Any scheme involving the reimbursement

of actual personal expenditure would not carry this incentive to economy. It is not conceivable that the Government would accept the principle of paying actual expenses unless it imposed at the same time a control of standards and direction over the expenses of such rigidity as to be highly undesirable in a profession where a high degree of individuality is essential, and, from the Ministry's point of view, costly administrative procedures would be involved.

34. There are defects in the present system, if it is regarded as having as its object the repayment to the individual doctor of each item of expense which he incurs. Short of requiring each doctor to submit detailed and individual claims for practice expenses to the Ministry, for which it is presumed he would be reimbursed, no scheme of distribution could achieve this result. The Council regards this as impracticable.

OTHER MATTERS AFFECTING GENERAL PRACTICE IN THE NATIONAL HEALTH SERVICE

35. The Council would now like to refer to a number of other questions in the field of general practice which, in its view, have a direct bearing on the issues now before the Royal Commission.

(1) The Relationship between General Practice and the Hospital Service

36. There is a clear distinction between the position of general practitioners and hospital medical staffs which is reflected in methods, as distinct from levels, of remuneration in the two fields. General practitioners are independent contractors, whilst hospital medical staffs, whether serving on a whole- or part-time basis, are salaried officers employed under contracts of service with the hospital authorities.

37. It is a comparatively simple matter to recommend detailed salary scales in the hospital service which will give effect to the Spens recommendations in present-day money values and restore proper differentials between consultants and other hospital medical staff. Very different considerations apply in the field of general practice, and the Council, in its Preliminary Memorandum of Evidence, has made it clear that it regards the Pool method of payment as the appropriate means of remunerating general practitioners, who, as a group, have undertaken collective responsibility for the population as a whole. The situation in this field is entirely different from the hospital service, where it is possible to devise a salary structure which reflects the varying degrees of responsibility involved in the different grades.

38. The Council would like to take this opportunity of emphasizing that general practitioners are opposed to a salaried service in N.H.S. general practice. Indeed, so strongly did the Association feel on this issue that at its instigation the Minister of Health embodied a proviso in the Amending Act of 1949 which states:

"Provided that the remuneration to be paid under such arrangements to a practitioner who provides general medical services shall not, except in special circumstance, consist wholly or mainly of a fixed salary which has no reference to the number of patients for whom he has undertaken to provide such services"

Now, as then, the Association holds firmly to the view that a salaried service in general practice would be detrimental to the interests of public and doctors alike.

39. The Council does not propose to submit detailed recommendations involving the distribution of the total sum made available for general medical services. Indeed, the Commission itself in its published statement of 12th April, 1957, made it clear that its duty to recommend current levels of remuneration "calls for recommendations covering, for example, average incomes and the desirable spread between extremes, but it does not call for the construction of detailed schemes of distribution," and the Council assumes that the Commission intends to leave it to

the profession and the Ministry of Health to discuss and agree upon a detailed scheme of distribution.

40. Apart from the difficulties of legislating in detail for remuneration in general practice, there are advantages to both the Government and the profession in maintaining some degree of flexibility. It has, for instance, been found necessary in the past to facilitate the entry of newcomers to general practice, and to provide interest-free loans to encourage group practice. The Council submits that these and similar arrangements are best left flexible and determined from time to time by those concerned with the day-to-day running of the Service in the light of the circumstances obtaining and with the detailed knowledge of both the medical needs of the community and requirements in general practice.

41. Whilst, for the reasons given above, the Council is making no detailed proposals on distribution in the general-practitioner field, it nevertheless wishes to draw attention to the need for a proper relationship between the remuneration of general practitioners and that of hospital medical staffs. That relationship was in fact determined by the Reports of the two Spens Committees which sought to ensure that these two important branches of the profession would secure their appropriate share of recruits of the right calibre.

42. The Council hopes that the Royal Commission will see fit to recommend steps which will result in the establishment of the differentials which the Spens Committee envisaged. In the proposals made for the remuneration of hospital staffs in the Council's Second Supplementary Memorandum of Evidence, it suggested measures which, apart from restoring proper differentials within the hospital service itself, give effect to the profession's claim for an adjustment to take account of changes since 1951, and, at the same time, seek some measure of redress for consultants holding merit awards. The Council believes that the implementation of its general claim would, to a large extent, meet the need for proper relativities between the hospital service and general practice in terms of global sums of money. Whilst at the individual level no direct comparison is possible, the Council is nevertheless anxious that the financial expectations of at least a proportion of general practitioners should compare favourably with those of practitioners holding the more senior posts in the hospital service. It is also anxious that the gap in total life earnings of the average doctor in the two fields should be properly related, for this is a vital factor in determining the choice of a career.

43. The Council believes that in general practice, no less than in other spheres, there is a real need for proper incentives if the best doctors are to be attracted to this important section of the National Health Service. It has been said that it is a serious disadvantage of the Pool method of payment that it does not provide sufficient incentives to the more able general practitioners, and that the knowledge that additional earnings from outside sources and hospital appointments make no difference to their total earnings is not conducive to the additional efforts which the extra work entails. The Council feels that this situation can, nevertheless, be met by equitable distribution and without any radical departure from the general concept of the Pool method of payment. As in other walks of life and other sections of the profession, incentives are necessary. The Spens Committee in Paragraph 13 emphasized this, and it is essential that sufficient additional money should be made available to ensure a proper relationship between general practitioners and consultants to be effected.

(2) Recruitment

44. One of the major objectives of establishing a proper range of remuneration in general practice is the maintenance of an adequate level of recruitment. As the Commission is aware, this question has recently been reviewed by the Willink Committee, who have recommended that the scale of admissions to medical schools should be curtailed for a period in the near future. As yet, the Association has not discussed the Willink Report with the Ministry, but it would like to emphasize that the steps suggested by the Willink Committee cannot in its view be taken to imply either that there are too many doctors or that the level of recruitment to the

N.H.S. in the future is properly safeguarded. The recommendations of the Willink Committee were necessarily based on the situation as it was at the time of its investigation and on official estimates of the needs of the National Health Service in the future. In the hospital service, for instance, the Council has already shown, in its Second Supplementary Memorandum, that the position in the registrar and senior registrar grades has been brought about by an insufficient expansion of the consultant establishment in hospitals throughout the country where a comprehensive consultant service was promised before the Appointed Day.

45. The continuing acute shortage of junior hospital staff, another factor which is causing considerable anxiety at the present time, indicates clearly that the problem is by no means solved. Furthermore, there must always be some "reserve" of doctors to meet the expanding needs of the community and who are available to augment the medical services when extra help is necessary.

46. As far as the quality of present-day recruits is concerned, the Council has noted the views given to the Commission by such authoritative bodies as the Royal College of Physicians and the Royal College of Surgeons of Edinburgh. It feels that they are more competent to comment on this particular question.

47. The fact that the medical schools have expanded in recent years is of itself no real indication that the financial rewards of general practice are sufficiently attractive to achieve the Spens Committee's objective of maintaining recruitment to the profession. At the time that the Spens Committee investigated the financial incentives of medical practice, new entrants to medical schools, and particularly their parents, were prepared to undertake the expense of medical training and the long deferment of earning power which is entailed not merely because of its vocational aspect but also because of the prospects which a career in medicine offered. To-day, the majority of medical students receive substantial grants towards university fees and subsistence, and in this way the Government has been able to ensure the maintenance of an adequate supply of new entrants to the profession. The Council, therefore, wishes to emphasize that the present level of recruitment to the medical schools does not provide a true basis upon which to examine the adequacy of present levels of remuneration.

48. The Council would like to refer to the question of emigration amongst doctors in general practice. Clearly, there has always been a certain amount of emigration, and, provided that it is kept within reasonable limits, it is to the advantage of all concerned and of particular value to the Commonwealth. The Council is, however, anxious that the trend should not grow to the point where an undue proportion of the more able doctors are attracted by better prospects outside this country. It is difficult to obtain detailed information on the subject, for there are no official figures available, but evidence already submitted to the Commission from other organizations suggests that there is an increasing tendency among students to look overseas for a career in the future. A memorandum on emigration of established general practitioners appears in Appendix B.

(3) Comparison with other Professions and Occupations

49. In the preliminary Memorandum of Evidence the Council referred in general terms to the scope, responsibility and rigours of the life of a general practitioner.

50. The Council believes that the difficulties and responsibilities, the hours of duty and the other factors in the general practitioner's life are so well known to all members of the community that it is unnecessary to go into detail. Nevertheless, comparisons have been drawn between the life of the doctor, notably the general practitioner, and that of others whose work entails long training and great responsibility. The Council does not dispute that there are other men and women who have long and difficult courses of preparation, long hours of continuous duty, and heavy responsibility. It firmly believes, however, that no other group shares with the doctor, particularly the general practitioner, all the burdens which the practice of medicine entails continuously throughout the doctors' working life and in which his family is usually involved.

51. Throughout his life as an established practitioner, the doctor has to make vital decisions affecting his patients. Although the number of patients allowed to each general practitioner is limited, the demands that can be made are unlimited as to time and number. These demands, sometimes irresponsible and unreasonable, are subject only to the whim of the patient, who, in making them, is under legal protection. This does not apply in any other comparable profession. Considerations of this nature must be borne in mind in any attempt to compare the remuneration of the general practitioner with that enjoyed by other professions and occupations.

(4) The Government's Memorandum

52. Finally, there are certain statements in the joint memorandum submitted by the Treasury and the Health Departments to the Commission which cannot be allowed to pass without comment.

53. In paragraph 29 of that Memorandum it is suggested that between 1948 and 1951 the number of "consultations" per patient increased from 5 to 5.5. The Council believes, although it cannot adduce statistical evidence, that with the increasing use of the National Health Service by the public the figure has further increased since that time.

54. In the same paragraph the average time per "consultation" is assessed at 10 minutes.

55. The Memorandum does not define the "ten minute average consultation." It is difficult to believe that it gives full weight to a night call, a call asked for late in the day (and these calls have increased), a maternity case (and midwifery forms only a small proportion of the late and night calls), a specialist consultation, or the considerable (and increasing) time spent in making telephone calls to hospitals and in writing reports.

56. *Pari passu* with the increased work in the hospitals, as described in paragraph 35 of the Memorandum (and in particular the last part of the paragraph), the time taken for each consultation has increased. It would appear, therefore, that the figures relating to 1951, if accurate for that time, are likely to be an underestimate in 1958.

57. The Council regards the dogmatic statement that the "more dangerously ill patients are admitted to hospital" (paragraph 89) as a misrepresentation of the work of the general practitioner, who, with the modern therapeutic measures at his disposal, is able to (and does) keep more of his "more dangerously ill patients" at home than hitherto.

58. In paragraph 76 the Memorandum refers to the comparable burden of work in summer and winter. The experience of general practitioners is that the difference between the amount of summer and winter work has diminished since the inception of the Health Service. The work is usually somewhat lighter in the summer months, but the influenza epidemic of 1957 readily comes to mind as an example that this is by no means always the case.

59. A simple arithmetical calculation will indicate, even if the Departments' figures are used as the basis, the long intensive hours of work of the general practitioner, including, for example, an evening surgery (for the benefit of the worker) often lasting to a late hour; hours of work that are not consecutive but spread through the whole of the twenty-four hours of the day.

60. The Council also wishes to emphasize that the figures given in the Memorandum exclude work done for other forms of practice which are remunerated outside the central pool, but which form part of the calculation of a general practitioner's income, as well as the time spent necessarily on the business and administrative sides of the practice and on keeping abreast of current advances in medicine.

61. In paragraphs 177-194 the Memorandum refers to the repercussions on the earnings of other groups which it is claimed would follow any increase in medical

remuneration. The Council believes that this argument has been greatly overstressed. The repercussions of the Dankwerts Award in 1952 were not widespread, and although the consultants award in 1954 may have had some influence on university salaries its effect can be overstated. Indeed, the later increase in university salaries in 1957 was quite unrelated to medical remuneration.

62. At times when incomes are rising generally, as during recent years, the rise is effected simply by repercussion of increases awarded to one group on the incomes of other groups. The Council cannot accept the argument that medical remuneration—or, indeed, increases in any part of the "public service"—should be exempt from this natural (and economically necessary) process. The main professional groups (civil servants, doctors, teachers) have a monopoly employer, and the argument that the Government expects those in the "public service" to accept income limitation even when it is obvious that wage-earners and salaried and self-employed persons in business and industry are not accepting it, implies that all professional incomes are to be depressed by the exercise of the Government's monopoly powers.

63. The arguments adduced in the Government's Memorandum are, in the Council's view, quite indefensible, and this policy has already failed in the nationalized industries, where the higher management are no longer compared with civil servants but receive instead something approaching the proper market rate of remuneration.

64. The argument is equally indefensible in the case of the medical profession, which has a right to expect that the remuneration it receives in the public service in this country shall be on a par with what it receives under the free conditions of other countries such as the Dominions or the United States.

65. The Council is certain that the Commission will wish to take all these factors into account when determining levels of remuneration for general practitioners in the future.

APPENDIX A

ENTRY INTO GENERAL MEDICAL PRACTICE

BY

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In 1955¹ and 1956² I published the results of inquiries into the incidence of unemployment and underemployment in the medical profession. The object of these surveys was twofold. First, to try to estimate the amount of real unemployment in the medical profession, and, secondly, to verify or refute the opinion I had expressed that too many would-be general practitioners were in posts which offered no prospects of advancement—that is, in what are colloquially described as "dead-end jobs."

In the spring of this year I undertook a third survey on similar lines. A questionnaire was addressed to all those registered with the Medical Practices Advisory Bureau, the great majority of whom were seeking to establish themselves as principals in general practice. On this occasion the scope of the inquiry was widened. It has been possible to analyse that section of the returns which included the so-called "permanent assistant," and, in the light of the Bureau's experience, to comment on the problem of entry into general practice about which so many different views are held.

It must again be emphasized that these inquiries have definite limitations. In the first place they comprise a selected group which cannot be regarded as a representative cross-section of the profession as a whole or even as a random sample of a particular section of the profession. Secondly, the Bureau has no monopoly, and

there are many seeking to establish themselves who have not registered with the Bureau or who have withdrawn their names temporarily because they are, for the time being, in appointments. Thirdly, the Bureau cannot nominate candidates for vacancies which are advertised, and this excludes from the scope of the inquiry the majority of single-handed practices—that is, Executive Council vacancies. With these reservations, however, it can be claimed that those registered with the Bureau form a group representative of those seeking to establish themselves in practice or trying, through exchange or other methods, to improve their circumstances.

Comparison of Figures

The total number circularized this year was 908. This is less than the number circularized in 1956 (947) and in 1955 (1,075). It is doubtful whether this difference has any significance, as the number registered with the Bureau at any one time varies considerably.

Analysis of Returns

1955	1956	1958
1,075	947	Total circularized ... 908
82 (8 per cent)	87 (9 per cent)	Returned form "un-employed" 63 (7 per cent)
265	153	Returned form asking to be removed from list because satisfactorily settled 150
248	179	Did not reply 201
480	526	Returned form "employed" ... 494

Unemployment

1955	1,075	Unemployed 82 (8 per cent)
1956	947	Unemployed 87 (9 per cent)
1958	908	Unemployed 63 (7 per cent)

These figures speak for themselves and support the view that of a selected group of doctors all seeking to establish themselves in their chosen field of practice rather fewer than 10 per cent are unemployed at any one time, and that this figure is likely to vary only slightly. I do not regard the lower percentage in 1958 as indicating a trend any more than the slightly higher figures in 1956 indicated a deterioration in the position. Since of the 63 who were unemployed when they received the questionnaire only 10 placed no restriction on the type of appointment or area they would accept, it may be stated with some confidence that the amount of involuntary unemployment in the profession as a whole is very small indeed.

I should like at this stage to add two further comments arising from criticisms of the two previous reports. First, it has been suggested that these inquiries have been made at a time when unemployment would be at its lowest. In fact, April was chosen deliberately as the month in which the seasonal demand for locums would be unlikely to affect the result. Secondly, it has always been difficult to decide how to deal with the number who did not reply to the questionnaire. On a previous occasion I gave figures to show that the great majority of these could be regarded as satisfied. On this occasion it was plainly stated in the questionnaire that those who did not reply would be regarded as satisfied and, in accordance with our usual practice (a twice-yearly check of the register), would be struck off the list of the Bureau. Including those who replied saying that they were satisfactorily settled and wished to be removed from our list, the total of those excluded from analysis is about 40 per cent as in previous years.

Establishment in General Practice

Of the 494 who answered the inquiry "employed" in 1958, 55 were not seeking posts in general practice; 38 others were principals in established practices seeking

alternative work or part-time appointments to supplement their incomes. These can therefore be excluded from the analysis, leaving 401 seeking principal status.

1955	1956									1958
480	526	...	Total...	...	...	...	...	...	...	494
30	43	...	(1) Registered with the Bureau but not seeking general practice posts	...	...	...	...	...	...	55
20	30	...	(2) Principals in general practice seeking alternative work or part-time appointments to supplement their incomes...	...	...	...	...	...	...	38
50	73	...								93
430	453	...	Net total	...	...	...	...	...	...	401
37	46	...	(I) Trainees	...	...	...	...	...	...	44
27	26	...	(II) In house posts or on national service and seeking first G.P. post	...	...	...	...	...	...	18
33	31	...	(III) Assistants with view to partnership who have asked to remain for the time being on the books of the Bureau	...	...	...	...	...	...	29
64	57	...	(IV) Principals seeking change of practice (exchange)...	...	...	...	...	...	...	59
161	160	...	Total	...	...	...	...	...	...	150
136	152	...	(V) Assistants without view	...	...	...	...	...	...	144
58	62	...	(VI) Locums or temporary appointments	...	...	...	...	...	...	47
75	81	...	(VII) Appointments with no prospects—e.g., registrars	...	...	...	...	...	...	60
269	295	...	Total	...	...	...	...	...	...	251

Note.—Groups I-IV not regarded as in dead-end jobs. Though all those in categories V-VII may be in dead-end jobs, only 35 (14 per cent) place no restrictions on the area or type of appointment they are seeking.

Analysis of Assistantships Without View

Out of the total of 144, 69 had done traineeships, and of these 48 were in their first subsequent assistantship, 21 had done more than one year as assistant, 19 (27 per cent) had been in general practice for more than three years.

Seventy-five had not done traineeships. Of these, 45 were in their first G.P. posts, 30 had had more than one assistantship, 12 (16 per cent) had had more than three years' G.P. experience.

It is usually accepted that a doctor who has completed his pre-registration house appointments and his national service and who may have done a further period in hospital posts must have at least two years' experience in general practice, either as trainee or assistant, before he is likely to be considered for an Executive Council vacancy. Experience suggests that at least a year's experience is also needed before a doctor seeking an assistantship with view to partnership can compete on equal terms for the more attractive openings. There are, of course, exceptions. There are partnerships which are "kept warm" for sons or other near relations; there are also assistantships where no view is offered but which result, after a varying length of time, in partnership. On the other hand, there are those who are content with the security of an assistantship without prospects which enables them to wait for an opening in a particular area or one giving opportunity for special clinical interest. If it is justifiable to assume that a doctor seeking to enter general practice must expect to serve for two years either as trainee or assistant before he can obtain the status of a principal, either in single-handed practice or in partnership, then it is reasonable to regard those with three or more years' experience who have still no expectation of attaining principal status as having been too long in dead-end jobs. It would also be true to say that during the first year no probationary post in general practice should be regarded as a dead-end job, and it is probable that this would be true also of the second year. The analysis of those in assistantships without view suggests that rather fewer than 25 per cent have been too long in this interim stage of their careers. This figure should be increased by an indeterminate number who

though in appointments without prospects, have either withdrawn their names from the register of the Bureau for the time being or have restricted, within a narrow field, the type of appointment they will accept or the area in which they will work. It is interesting to compare this estimate with the conclusion I published in 1955 that, out of a group of 1,075 doctors seeking to establish themselves in practice, 269 (25 per cent) were in posts which offer no immediate advancement or permanent security and which deny them the status of principal, to which, by reason of age, qualifications, and experience, they may well feel entitled.

Further evidence on the time normally taken to attain principal status is provided by the "turnover" of the Bureau. It is significant that although the number registered with the Bureau remains constant within fairly narrow limits—that is, between 900 and 1,000—few remain on the books for more than two years. The number circularized in 1958 who replied, and were therefore retained on the register, was 557. Of these the number who were also included in the 1956 survey was 129 (approximately 23 per cent) and the number included in the 1955 survey was 26 (approximately 4½ per cent). Of the 129 who could be assumed to be still searching for openings, 42 are not seeking posts in general practice. In the Bureau's experience the difficulty of obtaining an assistantship with view to partnership increases from about the age of 35 onwards, becoming a real handicap in the forties. Taking 35 as the borderline, it is interesting to note that, of the 129 included in the 1956 survey and still seeking posts in 1958, 80 (60 per cent) were over 35. Of those included in the 1955 inquiry and still on the books in 1958, 21 out of 26 were over 35.

Discussion

To discuss entry into general practice in terms of tables and statistical analysis is to oversimplify the problem. This approach ignores many important factors and takes no account of individual circumstances, qualifications, ability, and personality. For instance, given the requisite experience, age may prove a handicap when seeking a junior partnership but may even be an advantage when applying for an Executive Council vacancy. Again, if a doctor can accept the obligation to buy a house or to purchase a share in the capital assets of a partnership without having to devote too much of his expected income to the repayment of loans, he is in a much stronger position and has a much wider field of opportunity. Lastly, no counting of heads or the equation of the number of openings to the number of possible applicants will answer such questions as these: why a practitioner in a successful partnership with what seems to be an adequate income will suddenly decide to emigrate; why a doctor with family commitments and little or no capital fails even to investigate introductions which would seem to answer his needs; why a doctor will face debt and years of frustration rather than the "bogy" of the city or industrial practice, which in some cases amounts to almost an obsession.

The Bureau is continually faced with anomalies which are very hard to explain unless one is prepared to accept the fact that the difficulties of entry into practice are very greatly exaggerated. Though many could be quoted, two examples will suffice to illustrate this:

- (1) Owing to the retirement of a partner an assistant with view was required in a practice in an outer London suburb. N.H.S. list 5,000 plus. The new partner was required to purchase a share in surgery premises valued at £1,500 (alternatively the partnership would rent them). Salary as assistant £1,250 gross, commencing partnership share one-third, increasing to 49 per cent over eight years. Particulars of this vacancy were sent to 220 possible applicants. There were only seven applicants and the vacancy was subsequently filled after a private introduction.
- (2) An assistant with view was required in a rural practice based on a small town in south-east England. N.H.S. list 3,000 (mainly dispensing) and some appointments. Salary as assistant £1,250 gross, commencing partnership share of one-third with rights to increase "as may be agreed." Particulars were sent to 250 possible applicants, of whom 50 applied in three days.

A few months ago a firm of two partners in a country town some 20 miles from London asked the Bureau to introduce an assistant with view. The salary

offered during the probationary period was £1,050, with rent-free, unfurnished accommodation above the surgery premises. A commencing share of one-fifth was estimated to bring a net income of £1,500 per annum, with increases to approximately one-third after eight years. The new partner was required to purchase a share in the capital assets of the practice, which included freehold surgery premises, at an initial cost of just over £2,000. As there was scope for an increase in the amount of midwifery undertaken, preference would be given to applicants with experience in obstetrics.

The terms of this appointment as set out in the circular issued by the Bureau could be described as average. We should regard the area as "much sought after." Particulars were sent to 220 possible applicants, but only 25 applications were received. In spite of the deterrent—the need to find capital—we were puzzled by this small response, and, with the permission of the partners, I wrote to those who had not applied, asking for their reasons. About 80 replies were received.

The main inference to be drawn from the replies was that there was no sense of urgency, and though most of those who received the circular were in assistantships offering no prospects, and though many had expressed a preference for London and the home counties, they failed to investigate this offer of a partnership because *it was not quite what they wanted*. Many were deterred by the need to find some capital, others by the implication that for a time they would be required to reside on surgery premises though there was no indication that this was other than a temporary arrangement. A few jumped to conclusions which could not be justified either by reading the circular or by facts known to the Bureau. There may be good reasons for these suspicions, but if the need to attain principal status were pressing one wonders why so many did not even trouble to follow up the introduction or to make further inquiries. One doctor, in his reply, was frank enough to say that he had come to the conclusion that, because the midwifery was increasing and because an applicant experienced in obstetrics was required, this was evidence that the partners intended to pass all midwifery to the incoming man.

Many considerations influence a doctor seeking a practice or partnership. In the experience of the Bureau, by far the most important of these is locality. The need to find accommodation or capital, the initial share offered, and the time in which equality will be reached seem to be of lesser importance, though, as suggested above, these may give rise to suspicions which, though not justified, will deter the would-be applicant from even investigating the offer. If one accepts all that has been said and written about the difficulty of getting established in general practice, it is hard to explain why so many refrain from investigating good opportunities and the great reluctance of doctors to go to the large towns and industrial areas.

There is no doubt that one of the main deterrents is the widespread conviction that once a doctor attains principal status in general practice he is tied to that practice for the rest of his life. There is, of course, good reason for this. It is well known that the scheme for exchange of practices, though admirable on paper and sponsored by the Medical Practices Committee and the majority of Executive Councils, breaks down in practice because most of those seeking to exchange practices are looking for the same thing—a similar income in a more attractive area. The picture, however, is not entirely dark. A client of the Bureau has been successful in moving from the North of England to Somerset by means of three exchanges over the years. Nevertheless, the problem of restricted mobility remains.

Summary and Conclusions

Of 908 doctors who replied to a questionnaire circularized in the spring of 1958, 63 (7 per cent) were unemployed at the time. Since this group comprised those who were looking for posts in their chosen field of practice, the amount of enforced unemployment in the profession as a whole is very small indeed.

Of those in appointments offering no prospects of advancement, 144 were assistants in general practice. Of these some 22 per cent had been assistants (or trainees) for more than three years. If this figure is corrected to take into account those who had temporarily withdrawn their names from the Bureau, there

are probably between 25 and 30 per cent of those trying to establish themselves in general practice who have been too long in attaining principal status. The position is roughly the same as it was three years ago.

The experience of the Bureau suggests that the first steps are easy and there is no lack of appointments for trainees or assistants. Ordinarily, provided he is prepared to consider any good opening in any part of the country, a doctor should expect to attain principal status *within* three years of commencing his first general practice appointment.

Lastly, in the opinion of those dealing with the problem day by day, the position has been stable over the past three or four years, with recently a slight improvement in the number of the introductions made by the Bureau. As this coincides with the end of the first ten years of the N.H.S., it is impossible to say whether it represents a definite upwards trend.

REFERENCES

¹ *Brit. Med. J., Supplement*, 1955, 2, 11.

² *Ibid.*, 1956, 2, 127.

APPENDIX B

MEMORANDUM ON EMIGRATION OF ESTABLISHED
GENERAL PRACTITIONERS

This memorandum deals with the emigration of doctors who, up to the time of emigration, were principals in established general practice within the National Health Service in England and Wales since 5th July, 1948.

These doctors were, it is emphasized, men of middle age, with a substantial stake in the country, working in comparatively remunerative general practices, who for some reason preferred to abandon this and their homes, in order to practise abroad, mostly in other parts of the Commonwealth.

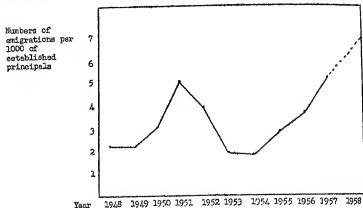
The figures we believe are reasonably accurate. They are derived from the returns of 124 of the 138 Executive Councils in England and Wales.

In the areas from which returns have been made just over 15,000 doctors practise. In those from which no return was obtainable just over 4,000 doctors practise.

The figures in the following Table reasonably represent the fluctuating rate of this emigration.

Year	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	Total
England... ..	14	31	41	69	50	26	27	40	53	72	423
Wales	2	1	4	6	6	3	—	1	2	4	29
Total (for six months)...	16	32	45	75	56	29	27	41	55	76	452
Rate per thousand doctors per year ...	2.13	2.13	3.00	5.00	3.73	1.93	1.87	2.73	3.67	5.07	3.13 average

For those who prefer a graphic presentation of statistics the one below may be of assistance.



Members of the Royal Commission will be aware that the Danckwerts arbitration was in 1951 and the working party's report deciding the agreed new distribution of the monies which came to the profession following the arbitration award was published in the summer of 1952.

It is submitted that the rise in the rate of emigration in the "pre-Danckwerts" period was significant of great unrest among established doctors. The subsequent fall to an average which we would submit can be regarded as a normal figure is equally significant, as again is the fact that mounting unrest has caused the figure to rise once more to a new high level in 1957.

When it is realized that many of those concerned in the 1957 exodus were within one year of their minimum pensionable period of 10 years in the Service, the figure becomes even more impressive. A rise to a figure of more than $2\frac{1}{2}$ times greater than that of the immediate two "post-Danckwerts" years (1953-54) in these circumstances, must not be disregarded. It is true also that this occurred despite the fact that the opportunities for a man to establish himself abroad have become progressively less in number during the past decade.

In addition a far greater number of unestablished doctors engaged in hospital practice up to the rank of senior registrar and also some of higher status and even of consultant rank have emigrated. The number of unestablished general practitioners who have also left this country is far greater, both relatively and absolutely, than their more fortunate established colleagues. There are, however, no reliable figures by which these can be classified.

Examination of Witnesses

DR. S. WAND, *Chairman of the Council*

MR. H. H. LANGSTON

MR. J. R. NICHOLSON-LAILEY

DR. G. WARING ROBINSON

DR. T. L. REEVES

MR. R. BREARLEY

DR. HAMISH WATSON

DR. I. RANNIE

MR. O. GAYER MORGAN

DR. A. B. DAVIES

DR. J. B. TILLEY

DR. H. D. CHALKE

MR. S. B. R. COOKE

DR. D. P. STEVENSON, *Secretary*

on behalf of the British Medical Association

Called and Examined

5438. *Chairman*: Dr. Wand, I take it that although quite a few of your large number of witnesses here today have not been here before themselves, our procedure is sufficiently well known by everybody on your side for me not to go through it again?—*Dr. Wand*: Yes, Sir. Would you like me to introduce the team?

5439. Yes, if you will.—*Dr. Stevenson* and *Dr. Tilley* you have met before. *Mr. Gayer Morgan* is a consultant ophthalmologist at Guy's. *Dr. Davies* you have seen before. *Mr. Langston* is now the chairman of the Council of the Central Consultants and Specialists Committee and, with him is *Mr. Nicholson-Lalley*. *Mr. Langston* is an orthopaedic surgeon in the south-west Metropolitan region, and an area director of orthopaedic services. *Mr. Nicholson-Lalley*, you may know, is a consultant in gynaecology and obstetrics in the Taunton area. *Mr. Brearley* is a senior registrar, in his tenth year as a senior registrar in surgery in the Liverpool area. *Mr. Cooke*, I think you know, Sir. Behind *Mr. Cooke* is *Dr. Rannie*, who is a senior lecturer in pathology, with an honorary consultant appointment in Newcastle. Next to him is *Dr. Hamish Watson*, a senior registrar in cardiology at St. Andrew's. *Dr. Hamish Watson* has also prepared that brilliant analysis in regard to the position of the Scottish registrars.

Dr. Waring Robinson is from Leicester and is concerned with the S.H.M.O.s Group. *Dr. Chalke*, who is Chairman of the Council of the Society of Medical Officers of Health, is here too. I think you have met *Dr. Chalke* before?

5440. Yes, we have. Now, during the last year or so we have traversed a lot of ground, including a good many things that are really on the fringe of our terms of reference. There are a good many things that we will not go into very great detail over today, partly because we know most of the answers and because we have had from the Joint Consultants Committee a lot of evidence on the position of consultants, much of which is repeated in your memorandum. So we will be concentrating on certain topics only. You will, I know, understand that that does not mean in every case that we are disinterested—though we may be in some cases; it may equally well mean that we have already covered the subject.—I wonder if I may say that when we first agreed to give evidence, we said we would give the Royal Commission all the possible help we could. I think in these documents we have gone into many of the figures, and I hope we have been able to give you a good deal of information. We have with us this morning three groups which I do not think have given oral evidence before—the S.H.M.O.s, the hospital junior medical staff and the ophthalmologists

in the National Health Service. We hope that you will get some information from them this morning.

5441. Thank you very much. You have indeed given us a great deal of evidence, and I might just refer to the fact that you did send us some little time ago your memorandum about arrangements for the review of medical remuneration. We had the opportunity of going through that with you at a private session and not in public. I mention that now because we naturally feel sure you would wish that to form part of our published evidence.—Yes.

Chairman: We shall print it together with some of these other memoranda that we shall be discussing today. Now I will ask Sir David to begin the questioning.

5442. *Sir David Hughes Parry:* May we take your second supplementary memorandum of evidence? In paragraph 3 you say that you have concentrated very largely on the problems of the more junior staff. Now in paragraph 5 you compare the position of the young doctor with that of other young professional men. That is in effect what you are doing when you say, "He has already reached an age when his contemporaries in many other walks of life have advanced to a point from which definite career prospects are in sight." What other professions had you particularly in mind?—We are speaking now of the junior hospital staff who are going to make their career in the hospital service. Having qualified, they have set their foot on a ladder, but it is not always certain that they can reach a point on that ladder when they can make a career of the hospital service, in the consultant grade. But in other walks of life, in industry—we say other walks of life and we do not say professions here—in other walks of life a man may become a solicitor or a barrister or an architect or an engineer, and he is already well set on to a ladder which will take him to his life's goal, in the ordinary sense of the word. With the hospital medical staff, they are not certain until a very much later age than this whether they will in fact have to change ladders. I would like at this stage, Sir David, to say that I have with me those who are most concerned with these problems, and although I am answering this question myself I hope to be at liberty to call on

my colleagues in these other fields, who may have some other statements to make.

Chairman: I was hoping you would do that, Dr. Wand.

5443. *Sir David Hughes Parry:* What I have in mind is this: the training in all professions now is much longer than it used to be. You would agree, would you not?—Some of them, of course, earn money en route. In some cases they have certain alternatives, which are easier than those before the doctors.

5444. Would you like to compare the position of the young doctor with the young barrister? That is fair enough, is it not?—I do not think one should take the particular profession, of a barrister, when it is well known that many men go to the Bar with no intention of practising at the Bar. Practically everybody who goes into medicine has the intention ultimately of practising medicine.—*Dr. Stevenson:* I think there is a difference, is there not, in the case of the young barrister. Whether he succeeds or not is very much within his own hands; it depends on his own ability. But in the case of the hospital doctor there may be no vacancy for him in the public service. He may be forced into another branch of medicine outside the hospital service—not because he is not capable of doing the work but because there is no vacancy for him.

5445. There may not be enough work for the barrister. He may have to change his career after a year or two of trying to practise.—*Dr. Wand:* It is well known that a barrister has before him opportunities in which law need only play a comparatively minor part and, indeed, some of them deliberately go to the Bar with the intention of doing something else rather than practising law.

5446. Let us take the very competitive position at the Bar, which could be said to be on the consultant level. You would agree to that? The top of the ladder is very high?—The top of the ladder is very high. The glittering prizes are very good.

5447. *Sir David Hughes Parry:* Would you compare it with the solicitor's profession? You see, 60 or 70 per cent of those entering that profession spend three years at the university, then three years in articles—six or seven years

of training; they may have to do two years of national service. It is a lengthy period again, as it is for the medical profession.—During that time most solicitors who are in articles are earning some money.

5448. *Sir Hugh Watson*: I would not like Dr. Wand to go on record in saying this, because I put this matter to the Secretary of the Law Society, and Dr. Wand is not correctly informed. I am told by the Secretary of the Law Society that the majority of solicitors when they are apprenticed earn very little indeed.—They earn something.

5449. Very, very little. I think Dr. Wand should bear in mind that medical students get a grant, and law students do not.—Not all medical students.

Sir Hugh Watson: They will, of course, be subject to the means test.

5450. *Sir David Hughes Parry*: 65 per cent. of medical students, I believe, get grants.—Yes, I said not all.

5451. *Chairman*: Dr. Wand, I want to be a little clearer than I am now on one point. Where you say in paragraph 5 "At this stage the young doctor is entitled to something more certain . . ." are you saying that anybody who wishes to end up as a consultant should, during his house officer year, be able to say "I have a right to be a consultant eventually"?—No, but there is, immediately after the house officer, the registrar grade. When a man is there he is trying to set his foot—not in all cases but in most cases—on the ladder of promotion, which ultimately will make him a consultant.

5452. Yes, that is when you say he "finds himself for the first time free to decide upon his future career, subject to opportunity and the restrictions of competition." You are saying he can take that decision?—Yes, it means he is approximately 25 years old, and at the age of 25 for the first time he can try to make up his mind in what form of medical practice he is going to spend his future life; and that, of course, depends in the consultant field on his ability to make the grade. I wonder if Mr. Langston might come in on this?—*Mr. Langston*: I think first I would say this, that a man who applies for and obtains a registrar appointment at least has some hope that he will ultimately become a consultant. He is not in fact chosen, at

this stage in his training, as a potential consultant but the course, from that point on, has become very much longer and, I think, more uncertain, towards the ultimate achievement of a consultant appointment than was originally envisaged. You have heard how one of our members here has been ten years a senior registrar. The registrars themselves often exceed their original agreed time of two years, so that that training period has become a great deal longer than was first envisaged. Furthermore if in fact one of these men working up the ladder realises at a late stage that he is not going to achieve his aim, he may have been on the training ladder for a large number of years and may have to go back to the beginning again, if he is going into general practice or public health. So that I think it is fair to say it is not quite the same thing as it is for a solicitor.

5453. *Mr. Langston*, I do not think we can go into the structure of the hospital service. There is a working party doing that. There is a considerable difference between the post of registrar and that of senior registrar, and one might be regarded as being much more of a training grade than the other. Are you saying that everybody who becomes a registrar should ultimately become a consultant?—No, certainly not, Sir.

5454. I thought you were rather implying that.—No, I was merely saying that a man who takes a post as registrar possibly has in his mind some hope of aiming at and achieving this object.—*Dr. Wand*: And at that stage there are no definite career prospects.—*Mr. Brearley*: I would like to make one comment if I may. I think we have strayed a little way from the text of what is written here. What is written is that "he has already reached an age"—and that is after qualification and after pre-registrar jobs and after service in the Forces, so it refers to somewhere about 30 years of age—"he has already reached an age when his contemporaries in other walks of life have advanced to a point from which definite career prospects are in sight." It does not say they have reached the point where they are already established in a career, doing well. We believe that at 30, in many professions, people can see what their career prospects are, whereas in medicine the position is not even at the beginning of

sorting itself out, and anybody who wants to go into the hospital side of the profession can have no idea of what his prospects would be.—*Dr. Hamish Watson*: I would like to carry it one stage further, if I may, and say that a solicitor or an architect endeavours to get himself into some firm at this age, and once he has done so he can quite clearly see his way ahead as a solicitor or architect in that firm for the rest of his professional life.

5455. *Sir David Hughes Parry*: The point is really the uncertainty, as compared with anything else?—*Dr. Wand*: Yes.

5456. Can I ask you to turn to paragraph 10? You say there "During this formative period of his life, the young hospital doctor. . . ." What age have you in mind there?—It is the age which has already been given, 25 to 30 or 32.

5457. Yes. Then you go on to say that he may have a family, and so on, and "this constant movement from post to post involves him in heavy expenses." I wonder what is meant there?—I think the experience of our younger members would help.

5458. Could we hear from the younger members?—*Mr. Brearley*: When a man comes out of the Forces at an age which is usually around 30 and seeks to follow a career in the hospital service, he is likely to get first of all, if he is successful with his application, a post either as a senior house officer or as a registrar. These posts have a one-year and a two-year tenure respectively, and while he is in those posts he will be engaged in studying for some further qualification. They are both posts of short tenure, and at the end of his period in each of these posts he will have to look for another post. In order to find one he may very well have to move to another area. So at this period of his life, whilst engaged in post-graduate study, he is in short-tenure posts and likely to have to move about from one area to another.

5459. At that stage?—At that stage. This is not a theoretical deduction from the terms and conditions of service, this is an actual fact; they will experience this.

5460. Until he is a senior registrar, when he is presumably stationary, is he?—If he is a senior registrar he has a

good chance of remaining in one area—although not a complete certainty.

5461. *Chairman*: You say this constant moving from post to post is experienced by the average person coming into the hospital service on coming out of the Forces, and you put the age at that stage as 30, which is much later than is usually put to us. But assuming that there is this constant movement, what does "constant movement" mean? It implies rather frequent movement.—I think he may probably get a senior house officer post in the first case; then a year after that he may make a move and become a registrar for two years, after which he may have to move again. During that period he may also have to take a course of study, which may not be available in the area in which he is then living; so it implies five moves over three years.

5462. You reckon it is a normal thing for these doctors to be moving five times in three years?—It is a common thing.

5463. I see. I must say I am surprised.—*Mr. Langston*: If I might make one point as regards certain qualifications which are sometimes acquired—for example, Fellowship of the College of Surgeons requires a man to obtain a post as casualty officer. That is a requirement, and that is an example of one of those moves.

5464. *Sir David Hughes Parry*: Can we now take paragraphs 17 and 18? You do emphasise in paragraph 17 that approximately three-quarters of consultants are "at present employed in a part-time capacity with the right to engage in private practice." We ourselves have calculated it at 70 per cent.; that would probably be the correct figure, about 70 per cent., who are at present employed in a part-time capacity. You go on to say that in the majority of cases this is from choice, though there are cases where the alternative of a whole-time appointment is not available. That leads first to paragraph 18, where you say "Private Practice, however, is known to have decreased considerably since the start of the National Health Service. . . ." Have you any evidence of this at all—this is a general impression, is it?—It is certainly more than a general impression; I think it is everyone's experience. Before the National Health Service many people were debarred from taking advantage of hospital facilities,

whereas now that it is a service open to all obviously a very large number of them have chosen to avail themselves of that Service, and obviously private practice has decreased. I think there is no question that it has decreased. Nursing homes have closed; there is plenty of evidence, I think, of the decrease.—*Mr. Nicholson-Lalley*: I would like to add to that, if I may. Nursing homes have closed—that is general experience all over the country—and alternative accommodation in the wards of the hospitals has not been increased, so far as I am aware; in fact, in some cases it has been reduced. Taking the case of a person like myself, before the National Health Service I lived entirely by private practice and I made an income then comparable to what I am receiving now from private practice and from the National Health Service. I have not got the figures, but I can say that, whereas at the inception of the National Health Service I maintained myself by private practice in a comparable and, perhaps, almost a better financial position than I have now, I did not do more than—I think it was 15 or 16 private major operations during the whole of last year—and that would have been quite insufficient to enable me to live under present-day circumstances.

5465. *Chairman*: Mr. Langston, we do not want to pursue this point very far, but this sentence of yours might mean that private practice by consultants decreased when the National Health Service started—which might be undoubtedly true—or it might mean it has gone on progressively decreasing since then, which is a slightly different point. Are you saying that private practice by consultants, not G.P.'s, is progressively decreasing?—*Mr. Langston*: That is what we are saying, Sir—that it has continued to decrease.

5466. On the whole I think it is true, Mr. Langston, that the proportion of part-time people engaging in private practice has not decreased. I think it has slightly increased in comparison with whole-time?—I think that is true, but I think there are reasons for that.

5467. *Sir David Hughes Parry*: Can we go on to the full-time consultant—unless there is something else that anyone would like to add to what has been said already in the memorandum as regards the hospital medical staff generally? It may be that we can

raise it again as we go along. I want to give you every opportunity of adding to what is here. Let us take the mileage payments. We would like to know what is included in the mileage payments here. We would like to analyse them. This is in the middle of paragraph 21—"It is rarely possible for a doctor of consultant standing to perform his duties without possessing a car, and yet the mileage payments that he receives from the Hospital Board for the use of his car in the Board's service can only rarely be such that he is not in fact providing a car for the Board's service at considerable net cost to himself."—*Dr. Wand*: I think Mr. Brearley would be able to answer this, because I think more or less the same situation arises, does it not, in the junior hospital staffs field?—*Mr. Brearley*: The question of whether mileage payments are equitable or not depends entirely on the mileage done, and as whole-time people are not entitled to claim certain mileages which part-timers are entitled to claim, they are more likely to find the payments insufficient where the mileage is smaller. The actual figures are 7½d. for a car of up to 10 H.P. and 9½d. for a car of over 10 H.P. This means if you have only a small allowable mileage, for example, such mileage as you do for going out to see emergency patients at night, you may only recover a matter of £50 a year, which is obviously quite insufficient to cover the cost of the depreciation of the car. Yet this car is very necessary for doing the work, and to my own knowledge an enquiry is sometimes made by the appointments committees as to whether a car is available for this purpose.

5468. *Chairman*: Is it suggested that people of consultant status would not normally possess a car if it were not for their work?—*Mr. Langston*: I think that might apply to some extent. It is certainly true to say, as we say here, that it would be difficult for many of these doctors to do their work without possessing a car and the Board has the advantage of that car and yet pays very little towards it. It is essential that the consultant should have a car, but he gets very little recognition of that fact from the Board who employs him.

5469. *Sir David Hughes Parry*: Is it not a fact that any person, really, of the status of a consultant—whatever his profession—has a car and runs it? You

see, it is a necessity of a profession, is it not?—*Mr. Brearley*: I am ready to suppose that many people of comparable status would use a car and do in fact use a car which they do not own. The car is provided by some employing body.—*Mr. Langston*: I live in an old cathedral city where there is a large public school, and many of the senior staff of that school use bicycles. I think that is a comparable instance.

5470. Comparable in status, but not necessarily in salary?—I think we are talking about status.—*Dr. Watson*: A further point which makes mileage payments rather unsatisfactory is that employing authorities will only pay for mileage done, say, between two hospitals. When making journeys on the hospital's behalf every day, one is only paid for the inter-hospital mileage. The Board will refuse to pay me for bringing my car from home to the hospital, and so the anomalous position arises that you cannot do the journeys without having a car, yet they will not pay you for bringing it. And this is a common thing. People use their motor cars a lot.

Chairman: I think that happens a lot in many walks of life.

Sir David Hughes Parry: That is, unfortunately, the same position as with university teachers.

5471. *Chairman*: There is also in fact a provision, *Dr. Watson*, that if the doctor has to have his car with him in order to carry out his duties he can, in certain circumstances, claim a mileage allowance for the journeys to and from his main hospital, subject to a maximum of 10 miles each week. There are certain provisions.—It is very difficult to get that.

5472. I do not think we can discuss how difficult it is in particular districts. There will always be differences in interpretation.—*Dr. Wand*: I have asked the junior staff representatives to answer this. They do not speak for the general consultants, of course, but the problem is much the same, and as there is no full-time consultant here I thought they might answer the question.

5473. *Sir David Hughes Parry*: I am taking the car as an example because it is the first thing which is mentioned in the list in paragraph 21. There are other examples. Now a person of consultant status would have a telephone

anyhow—that is also mentioned. The cost of books—another example—is a problem which arises in the same way in the universities. A university does not buy books for the staff; it provides some in the library.—*Dr. Stevenson*: The point here is that, as you know, this was all recommended in the Spens Report and has never been carried out—it is in the context of the non-implementation of the Spens recommendation.

5474. *Chairman*: And are you maintaining that it is one of the Spens recommendations that every whole-time consultant ought to have a telephone provided by the Board?—There is a difference as to whether the recommendation by the Spens Report ought to be interpreted as a definite instruction.

5475. And you are suggesting that should be done?—What should be done is that either they should be provided with these things in the form of tax-free allowances or that they should actually get an expense allowance, as Spens envisaged.—*Dr. Wand*: It is in paragraph 16 of the Consultant Spens Report—"Throughout our proceedings we have assumed that specialists engaged either whole-time or part-time in a publicly organised service will be paid any sums which represent expenses necessarily and reasonably incurred in the course of their work, and that these sums will be in addition to the salaries recommended. . . These include car expenses; expenses of travel apart from the use of a car; the cost of renewal of instruments and other equipment; the cost of books and journals, preparation of scientific papers, and subscriptions to professional societies; printing, stationery, postage and telephone costs; expenses of attendance at national and international professional meetings; and the expenses of visiting hospitals and clinics at home and abroad, and entertaining visiting colleagues."

5476. And it is your interpretation that they should be given a telephone free, because they need it for some purposes?—Not the telephone free, but telephone costs. The cost of the telephone is not only the cost of making a call.

5477. I just want to know what you are recommending. You are suggesting that the consultants should have the rentals of their telephones paid?—Well, Sir,

may I take myself as an example? I require an assistant in my general practice to have a telephone, and I pay the costs of the telephone. I pay the rental and I pay for outgoing calls in respect of his professional commitments to us. As an employer I regard that as my responsibility, in the same way as this is regarded in the Consultant Spens Report as the responsibility of the employing authority.

5478. *Sir Hugh Watson*: Have you ever tried to work the alternative which Spens suggested?—That being . . . ?

5479. A general allowance for expenses, attached to the post—that is the next paragraph?—Yes, that is the next paragraph. I am going to ask Mr. Langston to answer this.—*Mr. Langston*: We have tried everything.

5480. For instance, as regards solicitors, I am a partner in a large firm. I have a telephone and I incur travelling expenses and I have to do entertaining. What happens is that, by agreement between the partners, each of us is paid £X for this purpose and that is all there is to it.—*Dr. Wand*: I gather that all efforts have been made, and every channel has been explored, to obtain the implementation of the recommendations in paragraph 16, and they have been of no avail.—*Mr. Langston*: Yes.

5481. You see, one of the great difficulties here is the interpretation of No. 16, and the Ministry—and probably particularly the Treasury—are inclined to interpret the Spens recommendation at No. 16 very narrowly. It occurred to me it might be easier to take a broad axe to it and give a sum of £100 for expenses, instead of having to argue about telephone costs and books and stationery, etc.—*Mr. Langston*: Something of that sort, I think, would be satisfactory to us.

5482. *Chairman*: Would there not be a very great variety in the amount of expenses actually and legitimately charged under the present ruling?

Sir Hugh Watson: Spens contemplated that, too, Sir.—I think there might have to be a variation from post to post.

5483. *Chairman*: It is one of the points which incurs dissatisfaction?

Sir Hugh Watson: And the dissatisfaction is the disappointment felt that there has been no implementation of the Spens recommendation.—*Dr. Stevenson*: That is the point of this paragraph.

5484. *Sir David Hughes Parry*: The point you make in paragraphs 26 and 27 has been made on several occasions to us, and I do not think anything need be added to it. Then we have the point that you make as to the special distinction awards and how you suggest they might be arranged. We have that point. I do not think I have anything on that, or on domiciliary consultations. I think we have gone fully into that on several occasions—unless there is something which anyone would like to say?—*Dr. Wand*: No, thank you.—*Dr. Stevenson*: Except that we are in full agreement with the views expressed by the Joint Consultants' Committee on domiciliary fees.

Sir David Hughes Parry: Then we come to the section on Senior Hospital Medical Officers.

5485. *Chairman*: I think a very great deal of this section is necessarily much more within the province of the working party than it is within ours, so we shall probably spend very little time on that.—*Dr. Wand*: Yes, but in the meanwhile we do want to stress the point that the proper remuneration is 80 per cent. of the consultant remuneration.

5486. That is what is printed in italics in paragraph 66.—So long as this grade lasts.

5487. *Sir David Hughes Parry*: I am in a little difficulty to understand what chances of promotion there are for the senior registrar. Is his only chance of promotion into the consultant grade?—*Mr. Brearley*, I think, will speak on this, because so many of the senior registrars who have failed to obtain consultant posts apply for S.H.M.O.—*Mr. Brearley*: Dr. Watson has also prepared a detailed study on this subject, and I am sure he will want to speak about it, too. The members of the senior registrar grade have entered that grade for the purpose of securing promotion into the consultant grade, and I think you could say that the only satisfactory promotion open to them is into the consultant grade. It is true that many of them, feeling that, after prolonged attempts, their chances are so poor that they must settle for something less, do ultimately find themselves in the S.H.M.O. grade. I think the representative of the S.H.M.O. grade will be able to give you a better idea of the numerical size of that body.

5488. Could I, at this point, ask you whether in principle all S.H.M.Os. do become ultimately consultants?—*Mr. Langston*: I think that is one of the troubles—that relatively few do. In other words it is an end grade for a very large number. It is the top of the ladder for a number, in spite of fights for regrading and the like.

5489. Who does the regrading of S.H.M.Os.?—There was a regrading committee which completed its work in 1951. That is one subject of our concern—there has been no regrading of these men, in spite of their further training and further experience, since 1951, yet we know many of them are doing consultant work and undertaking consultant responsibility.

5490. Was there dissatisfaction with the regrading in 1951?—I think there was a measure of dissatisfaction, certainly, but the dissatisfaction now is the fact that although these men have had further training and experience they have had no opportunity of being re-examined. I think there is a great deal of dissatisfaction also with what we consider to be the abuse of the Ministry's circular—which I think we quote in our appendices here. This was an agreed circular which, if it had been strictly adhered to, would not have allowed the very considerable expansion of the S.H.M.O. grade which has, in fact, taken place since then.

5491. *Chairman*: That part would not be for us, but it is correct that any S.H.M.O. can apply for a consultant post?—*Mr. Langston*: Strictly, yes, but he applies in competition with the young senior registrars and you well know how many of them there are competing with him. I think if you are filling a vacancy in a consultant establishment you will always have in mind your age distribution and you are not very likely, for example, where you have a consultant of 50 odd, to bring in a S.H.M.O. of 45 if you have a fully suitable senior registrar who is under 40. So that many of them, in any application, are at a considerable disadvantage.—*Dr. Wand*: I wonder if you would like Dr. Reeves to answer this question about the S.H.M.O.? He will tell you of the anxiety which followed the review of 1951.

5492. *Sir David Hughes Parry*: May I ask, before he begins, who did the

review—what was the directing body?

—*Mr. Langston*: It was a review initiated by the Ministry at the request of the Joint Consultants' Committee. The personnel of it, I think, were all doctors in the main chosen by the Ministry.—*Dr. Reeves*: I would like to add that this review was only brought about after very strong dissatisfaction had been expressed, and it was initiated as a result of protests coming to the S.H.M.O. organisation through the profession. Numerous attempts have been made to re-open the regrading committee subsequently, all of which have failed. We have never succeeded in getting any machinery by which any form of continuing review can be established; and that is one of our aims because, as I understand at the moment, the S.H.M.O. is a dead end, with no future prospects of getting out of the grade.

5493. *Sir David Hughes Parry*: I think we have the point now. May I take one point in paragraph 59? You deal with chest diseases and the increase—or almost decrease—of consultants in that specialty. Is there anything in that speciality itself that accounts for that?

—*Dr. Reeves*: We believe this is the result of the misuse of Circular R.H.B.(50) 96. There has been, of course, a change in the practice of medicine in diseases of the chest but there should not be, under the present evolution of the chest diseases, such a decrease of consultants and an increase of S.H.M.Os. It should be the other way round, because all the men working in diseases of the chest are intent on raising the standard to a far greater level. In point of fact what has happened, as you see, is that a larger number of S.H.M.O. appointments have been made than consultant appointments.

5494. *Mr. Bonham-Carter*: If I might put one further question about S.H.M.Os. I quite see the difficulty which arises because they have become what you call a dead-end post. Is it not normal to have dead-end posts in all walks of life? In other words, some people will never get beyond a certain stage, whatever profession they take. And wherever they stop, as far as those people are concerned, they are dead-end posts. I think I know what your answer will be, but there is something else which particularly needs to be said, is there not?—*Dr. Stevenson*: The fact that they are in fact doing consultant work.

5495. I think that is the important part of this.—*Dr. Wand*: And that some of the jobs, indeed many of the jobs, on retirement are regraded as consultant posts.

5496. *Mr. Bonham-Carter*: But you cannot protest, can you, that if there were enough consultant posts there must always be a certain number of people who stop at S.H.M.O. or stop somewhere? Would you accept that?—*Dr. Reeves*: They stop because they cannot get beyond S.H.M.O.—*Mr. Langston*: A S.H.M.O. is supposed to be under consultant supervision, but in point of fact a great many of them are under no supervision whatsoever.

5497. *Chairman*: You will appreciate that is not a point we could possibly assess or deal with.—Yes, but it has a bearing on remuneration.

Chairman: We cannot possibly know the extent to which that is done.

Sir David Hughes Parry: That is all I have, Sir, on this memorandum.

5498. *Chairman*: Have you any other points, Dr. Wand, you would like to make with regard to the junior hospital staff generally, or which you wish to raise on this memorandum?—I think Mr. Brearley and Dr. Hamish Watson would like to make some points.—*Mr. Brearley*: There are many considerations here which are proper to the working party rather than to this body, and it was never our intention to come here and ask you to review the problem of junior hospital staffing. But we do want to draw to your attention that it is because of the consequences of the present method of hospital staffing that the junior hospital staff face certain hardships which have nothing to do with the general basis of the profession's claim, which is concerned with the betterment factor. We wish to draw your attention to the fact that the Spens plan of remuneration was conceived in terms of a certain life schedule, as it were, in which a man would progress through certain grades at more or less certain ages. The outcome of such a progression would be that he would attain a certain figure for his whole life earnings. Now, the amount of earnings which may be attained in the whole of his professional life by a man who is at present on the junior hospital staff, that is to say, a man who we think should be retiring from a consultant post some

time after 1980, will be very much less than Spens intended, even taking into account the Spens recommendation of the betterment factor, because he is spending so much time in a junior post on the lower remuneration and has therefore a correspondingly shorter period in the higher grade on the larger remuneration. While we realise that it is not the work of this Commission to alter this situation, we wish you to recognise that it is always a danger inherent in any monopoly-employer arrangement such as we have; and we would like to feel that your recommendations, when they are made, contain conditions which would mitigate as far as possible the effects of such bottlenecks, both now and at any time in the future, if they should occur again. It is for that reason that we have pressed very strongly certain points. They are, first of all, that in the registrar grade there is now a bottleneck because of the hold-up amongst senior registrars, there should therefore be an extra increment of salary to middle-grade registrars who are kept on over two years. The reason a man is kept on for over two years in that grade is generally because he is considered to be a suitable candidate for the post above, and he is simply in the lower grade waiting for a vacancy in a higher one. There should be an arrangement which will allow him to enter the senior registrar grade on the next incremental tier above the one in which he was placed when he was in the middle registrar grade. The same thing could be operated in the transition from senior registrar to consultant. There is a very large gap between senior registrar and consultant—over seven years of increments. Thus a suitable man with eleven years in the grade can be provided with seven years' increments without the figures overlapping in the salary scales at all. Furthermore, there is a provision already in the terms and conditions of service allowing at discretion the granting of extra increments for men entering the consultant grade at an age greater than that envisaged by Spens of 32. This is an optional arrangement at the moment, and although there have been recent instances of it, it is not something which has been overworked. We believe that as the arrangement by which people promoted below the age of 32 is obligatory, this should be obligatory too, and the limit of four years should be

removed. That provision would enable the man to reach his maximum earning at about 40, and maintain his maximum earning, as the Spens Committee intended.

Our views on tax allowances and so on have already been stated. There is one last point relating to the way in which the salary scales have been calculated. If you will look at Appendix VIII you will see that the Spens Report proposed a set of differentials, which are in the first column of Table II. We have taken our fixed point as being the lowest figure on the consultant scale. The senior registrar salary scale of Spens finished at 80 per cent of that figure, the range being 60 per cent to 80 per cent, and so on, down the table, where each figure is calculated as a percentage of a fixed figure, the starting salary of the consultant. The scales which were operated up to 1954 did not differ very greatly from the Spens differentials, but as a result of the 1954 award the balance was upset very greatly; in particular the gap between the top salary of senior registrar and the consultant minimum widened from 20 per cent in Spens to 34 per cent. In our calculations we have recommended the starting salary of the non-merit award consultant as being the basic figure, and we have calculated what each other grade should be paid as being the same percentage as agreed in the Spens recommendation. These restore the differentials that were envisaged in that award. Those are the points to which we attach the greatest importance.

5499. Thank you. We have them in mind, and you have set them out very clearly for us. Dr. Hamish Watson, I believe you wished to say something?—*Dr. Hamish Watson*: I would like to make one point, to re-emphasise what has already been written here, that the salary scales recommended by Spens for the earlier years were originally designed to supplement what in those days were the lean years, while a man was training to become a consultant. For the great majority of people in the junior ranks their lack of security and promotion prospects is a much greater worry than their financial state. Whereas in the past it was said of them that they had failed to get consultant jobs, from the figures we have produced, for Scotland anyway—and there is no reason to believe they are any different south of the border—it is now true to say there are just no jobs available for these

people, and this is having a detrimental effect on recruitment to the hospital service. As we say in paragraph 83, it is a very brave young man now who takes the risk of embarking on a hospital career, because the circumstances would make it improbable, the way things are, that he would be successful.

Chairman: Now, can we turn to the other memorandum—your third supplementary memorandum of evidence?

5500. *Sir David Hughes Parry*: We have heard Dr. Chalke on this, and I find some difficulty really in asking any questions at all that we have not covered before. Can I put it in a general way—is there anything that you, Sir, or Dr. Chalke, would like to expand or expound on this?—*Dr. Wand*: Dr. Tilley is Chairman of our Public Health Committee. Dr. Chalke is Chairman of the Society of Medical Officers of Health; it was in that capacity that he came here before.

5501. *Chairman*: I think we understand, Dr. Tilley, that quite briefly the desire of the public health doctors is to be treated as doctors and as nothing else—is that right?—*Dr. Tilley*: Yes.

5502. Do you want to add anything to that statement?—I have nothing to say that is not in here. All I would say to Sir David is that we would reinforce that the Commission, in considering what it has to consider, should not think that all is well in the public health service, if it is going to consider the public health remuneration as a matter of comparison. There is considerable dissatisfaction, as has already been said to the Commission, which is resulting in, in our opinion, recruitment at an inadequate professional level. We hold that will ultimately be to the disadvantage of the national health. We have given you the details of a scheme of revision within the public health service, which we think would be of value. I could argue that with some force, but this is not the place.

Chairman: No, I think not. But we have these views.

Sir David Hughes Parry: The only thing we would like to do is to reassure you that we are aware that there may be repercussions on the public health service as regards any recommendations that we make. That is the utmost, I think, that can be asked of us.

5503. *Chairman*: Do you want to add anything, Dr. Chalke?—*Dr. Chalke*:

No, Sir; I heartily agree with Dr. Tilley as regards the salary and the recruitment particularly, and the standard of the profession.—*Dr. Wand*: There is one thing—the point we make in the last few lines of paragraph 38. You will remember at one time when this Royal Commission was instituted, there was some discussion about the inclusion of public health officers within its remit, and the public health doctors hope that the Royal Commission will give some sympathetic consideration to the hope expressed in that last sentence.—*Dr. Davies*: May I add, Sir, on behalf of the general practitioners, that we do support the public health medical officers in all aspects of their case. We do regard them in this tripartite form of health service as the Cinderellas, from a remuneration point of view. But they are doctors, they are essential to the National Health Service, and we in the general practitioner sphere think very highly of them.

Chairman: I felt inclined to say, Dr. Davies, that if they are the Cinderellas, what are the other two branches? *(Laughter.)*

5504. *Professor Jewkes*: You say in paragraph 46 that there is great anxiety about the position of what we might call the medical pre-clinical people in the universities.—Yes.

5505. And then you go on later to make certain recommendations about the scales for medical teachers and research workers in clinical posts. But you do not say anything about pre-clinical salaries. I presume you have deliberately excluded those because you do not feel it is really our direct concern—or do you want to say anything about this? —*Dr. Wand*: I would like Dr. Rannie to speak about this.—*Dr. Rannie*: I think in paragraph 51 we say that recruitment to university and research posts, whether they are clinical or pre-clinical, will only be satisfactory if the eventual total remuneration is such that it compares not unfavourably with that obtaining in the consultant and specialist branches of the profession. I would like to reiterate that in the pre-clinical stage the total remuneration possible in the case of a professor or his equivalent in employment with the Medical Research Council, is very much below that at the moment, even comparing with basic consultant salary. Where you get a

consultant at the top of his profession and with a full-time merit award, then the difference in remuneration is almost of the order of 50 per cent.

5506. *Chairman*: You will know, Dr. Rannie, that we are getting information about university teachers' remuneration in general, as well as about the particular professions.—I was rather alarmed to hear that some of the pre-clinical teachers in anatomy had been approached as doctors in a comparable profession, rather than just as doctors. After all, we are all linked together, and those of us in the Health Service, by virtue of the honorary contract, regard ourselves as an integral part of the Service, and although we are not remunerated directly by the Health Service we have a contract with it. We are under the same terms and conditions of service—we have to get permission for leave, and so on—so that I would like to make it fairly plain that, as far as university teachers and research workers in the Medical Research Council are concerned, we would like them to be considered as a solid, not a divisible, body.

5507. *Professor Jewkes*: Can we then assume in paragraph 52 where you say "The following scales are recommended for medical teachers and research workers in clinical subjects . . .", you want to include pre-clinical in that? In these paragraphs you do not make any recommendation about pre-clinical remuneration, and I wondered if you wanted to do that.—*Mr. Langston*: I think, Sir, the pre-clinical ones are not in the National Health Service. We are dealing with those who are remunerated in the National Health Service, and as far as they were concerned we could not possibly go further than say that the remuneration should "compare not unfavourably".—*Dr. Wand*: And indeed representations will be made in another quarter on the question of pre-clinical teachers.

5508. *Chairman*: You probably have seen the evidence that we received when the Medical Research Council gave evidence here, and broadly your feelings are, I think, in line with that?—Yes.

5509. *Sir David Hughes Parry*: You realise there will be new repercussions on the salaries of the university teachers in other departments?—*Dr. Rannie*: That has happened before, and it is only because of repercussions that the uni-

versity teachers have got to where they are. It is still only two-thirds of what their Health Service opposite number is getting.

5510. *Chairman*: I do not think it has ever been implied to us that anybody in any university feels that all professors ought to be exactly level, but if I have got it right, I think on your recommendation here your readers in clinical subjects would end up earning a good deal more than the professors in some other subjects—is that right?—That is true.

5511. And you feel that would be an acceptable thing?—Yes, it would be an acceptable thing, and I think it would have to be pointed out that professors in many other subjects apart from medicine have got other ways of increasing their remuneration.

Chairman: Yes, that again is a matter on which we shall receive some factual information which should be very useful.

5512. *Professor Jewkes*: I am just making quite certain what is really being suggested here. Medical teachers and research workers in pre-clinical work, of course, do not qualify for merit awards, so for that reason there will always be this earnings gap between the clinical and pre-clinical groups. You are prepared to accept that, are you?—*Dr. Wand*: I think, as we said before, we would take up the appropriate remuneration of pre-clinical people in the quarters concerned, and would make a strong representation of the differences which obtain because of the merit award system.

5513. *Chairman*: You are suggesting in effect that if the Medical Research Council, for example, were employing pre-clinical people, they should be free to pay whatever was necessary, since these employees obviously could not qualify for merit awards, as do the clinical people?—*Dr. Rennie*: I have one further point: that is that the dentist in the university is in the same position as the medical profession here.

Chairman: Yes, we appreciate that for this purpose the dentists and the doctors are at one.

Sir David Hughes Parry: We come now to the section on the supplementary ophthalmic service.

5514. *Chairman*: Could you tell me just briefly how many of those who carry out sight testing are not medical

practitioners? Are the ophthalmic medical practitioners a small proportion of those who do sight testing?—*Dr. Wand*: Yes, Sir.

5515. How small, about?—*Mr. Morgan*: There are roughly about 800 ophthalmic medical practitioners and roughly about 8,000 ophthalmic opticians.

5516. And I think it is right, is it not, that all the sight testing fees here come out of the central pool?—They are paid through the Executive Council.

5517. Yes, it comes from the central pool?—*Dr. Stevenson*: Only in so far as the person undertaking the sight test is in fact part-time in general practice and is participating in the pool. That is only a small proportion of the total to which Mr. Morgan referred.—*Dr. Davies*: Only those doctors who are registered with an Executive Council.—*Dr. Stevenson*: Shall I put it this way: there are, say, 1,000 of these ophthalmic medical practitioners; only a proportion of them are in general practice. In so far as this proportion receive sight testing fees, those fees will come from the pool; but the great majority of them are not in general practice, and their fees are a charge on the Exchequer funds.

5518. What are the great majority of those 1,000 doing, apart from sight testing?—Consultant work.—*Mr. Morgan*: Probably about 65 per cent have some connection with the hospital service.

5519. You give us a great deal of history here, bearing on your recommendation that this particular group should receive a rather extra specially large increase compared to other doctors, is that so?—*Dr. Stevenson*: No, Sir, exactly the same.—*Mr. Morgan*: We do perhaps stress the point that in our negotiations with the Ministry the salary scales have come down, whereas the standard of the actual medical practitioners has gone up through the increased requirements of the Ophthalmic Qualifications Committee, so that everybody now who gets on to that list is really a specialist.

5520. *Dr. Stevenson*, you said "exactly the same," but I think in paragraph 89, unless I misunderstood it . . . —*Dr. Wand*: Yes, you are quite right, in paragraph 89 there are really two elements.

5521. There are three. You say that even if the £1 is taken as the basis,

which you do not think it should be, then there would be need for a twofold increase.—*Dr. Stevenson*: We have not said here that we do not think the £1 would be right, we say we do not accept it. What we do accept is that it should be tied up with the remuneration of the consultant in the hospital upon which the £1 fee was based.

Chairman: Do you want to say much more about this? I think this matter is quite clearly set out. If there are no questions on this by any other members of the Commission, then I think that concludes that particular memorandum. We have got two more memoranda from you here, *Dr. Wand*. The fourth supplementary memorandum really answers a good number of questions that we had asked you previously, and I personally have no further questions.

5522. *Professor Jewkes*: I would like to ask one question on this, on the section relating to recruitment, *Dr. Wand*. There you point out that the Willink Committee recommended that the scale of admissions to medical schools should be curtailed for a period in the near future, and I think many people would have thought that that meant at least that there were enough doctors and that at least the rate of entry was not unsatisfactory. But you in effect challenge those deductions. I wish you could just enlarge upon that a little, because it is to outsiders somewhat confusing.—*Dr. Wand*: Of course, the main principle is that the work of the doctor in the National Health Service is just growing and growing and growing. I think that is probably the most important factor.

5523. Did not the members of the Willink Committee know that?—We have a member of the Willink Committee here now, and I wonder if he would like to say something?—*Dr. Davies*: Mr. Chairman, I did make some comments on this situation at the request of one of the members of the Commission some time ago. The Willink Committee reported on conditions which obtained during the time of its sitting, between 1953 and 1955. I did remind you on a former occasion that the Committee did quote on almost every page the fact that it was dealing with imponderables, and in its final recommendations would assume that a fair degree of latitude must be allowed. Furthermore,

they suggested that at a later date another committee of a similar kind might take up an investigation again, because the further one probed into the future the more unreliable estimates would be. But the recommendations themselves, such as they were, in 1955, depended on certain things not happening: war was one, a political alteration of the health service as regards expenditure of money and requirements was another, and thirdly, a factor which was also unknown, the effect of some major scientific discovery. Now those things to which I have referred were all necessary qualifications, and one must admit that it did subtract a little from the value of the report. It is quite true that the Committee did report that at a time which is not now very far ahead a balance would be struck between the output of the medical schools and the requirements of the nation in the health service sphere, on the basic requirements to which I have referred. At that time, according to the Willink information, it was estimated that a 10 per cent. cut would possibly be required, and advice to that effect would be made to the Deans of Medical Colleges.

5524. *Chairman*: That was a 10 per cent. cut in what was likely to be the level of recruitment?—Yes.

5525. It was not a 10 per cent. cut in what had been happening?—No. And from that point there was an opinion that at a later time in history, I think 1975 was the date—I am speaking without the document now, but I think it was about 1975—the position would be reversed, that a greater output from the medical schools would be required. Without looking at documents, Sir, and from my memory, I have tried to give you the position, as a member of the Willink Committee.

Chairman: Thank you.

5526. *Professor Jewkes*: The Willink Committee apparently made certain assumptions inevitably regarding the period 1953-55, and they reached a certain conclusion. Is there any reason to believe that those assumptions were not the correct ones? If the calculations were done again would you want to change the assumptions? Is there any change there?—No major differences, Sir, but you may well remember there

was a point on which both Dr. Wand and I were questioned in the general practitioner field on the items of service issue, where we indicated that while there were no up to date figures since the Professor Bradford Hill figures, we had the experience and the opinion that the number of items of service had gone up a little. Moreover, and this is a point to which I made reference, there is an opinion based on experience that the time taken over each patient is longer to-day than it was formerly. Both Dr. Wand and I did say that, to give you some indication that there was a move in the time expenditure of doctors which ultimately might reflect itself if another Willink Committee were set up. I think there is very considerable support from our experience that things are going that way. So it may well be that the Willink recommendations may not prove to be as reasonably accurate as we thought at the time. In other words, I am trying to tell you that there could well be a margin of error—slight, it is true.

5527. But would it be such a margin of error that although the Willink Committee was recommending a cut in entry, really the right answer was an increase in entry?—I do not think it would go that far, Sir.

5528. *Sir Hugh Watson*: Was any member of the Willink Committee contemplating a reduction in the size of lists?—That was not within the remit of the Willink Committee.

5529. No, I know, but it is a thing that is talked of.—Reference was made to the opinions of the Cohen Committee, which did not commit itself on the size or reduction of lists. You may remember that the Cohen Committee held the view that the present numbers were within the competence of a good practitioner in a well organised practice.

5530. *Chairman*: I believe that brings us to the end of these rather long series of memoranda apart from one or two extra documents you submitted to us. These were a record of an attempt to reopen the payment of compensation for loss of goodwill, and some copies of correspondence between the Health Department and the Association. But those were just submitted as a means of showing us that you found the Government difficult to negotiate with, is that

not so?—*Dr. Wand*: I think there is plenty of evidence of that.

5531. I do not think we need necessarily decide that those two particular documents, which have only a very indirect bearing on our task, require separate publication with the rest, but we will consider that later. Of course we are not publishing everything that everybody sends us in any case, so that I am not undertaking that we will publish these even if you thought they ought to be.—I have just got before me the one on the remuneration claim, negotiations on the validity of Spens—we should be very happy indeed, I think, if you saw fit to publish that.

5532. I have no doubt. I think we can leave that. I am just telling you that we have not made up our minds whether to do so or not. Are there any other points you would wish to make, Dr. Wand?—Yes, there is one point, quite a short one. It is the question of when we may have an opportunity, Sir, of seeing the figures that have been thrown out by the various enquiries. You recall, Sir, that we did express a wish to see them in sufficient time to be able to make comments on them if we so desired. We note that the present zero hour is somewhere, we hope, in the very early summer; the time is drawing near and we may need a little time to look at them and to realise all that they mean.

5533. All I can say on that at the moment, Dr. Wand, is that no figures have yet reached the Commission at all, although our statistical committee have seen figures in respect of a total of four groups, which are being reduced to manageable proportions. They were in respect of general practitioners, consultants, S.H.M.Os., and one of the outside professions. It will be a little time before there are enough of those reduced to a useful stage to show you, but we will certainly take the earliest opportunity of doing that. We are not intending to let you have the enormous mass of statistics that we have considered were too much even for the Commission as a whole. We are thinking that the kind of figures for you would be those that the Commission will have.—Yes, Sir. I take it that the figures will give us a sufficient amount of information to enable us to read into them what can be read into figures.

5534. I should think it would give you a very great deal more. If we could reduce it only to that level, I think we would be delighted. Therefore I am afraid we cannot give you a precise date, but we will keep in touch with Dr. Stevenson in order to let you have that at the earliest possible moment.—Yes, I do not want to over-stress this point,

but it is a question of getting groups of doctors together in various fields, collecting all their information and so on, and getting their expert advice. It is a time-consuming series of manoeuvres and we do not want to delay the ultimate report of the Commission, Sir.

Chairman: I appreciate that, Dr. Wand.

(The witnesses withdrew.)

ROYAL COMMISSION ON DOCTORS' AND
DENTISTS' REMUNERATION

APPENDIX
TO THE
MINUTES OF EVIDENCE

*Selection of Witnesses'
Supplementary Statements*



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INTRODUCTION

The written and oral evidence of the 27 Government Departments, associations and organisations examined in public sessions of the Royal Commission has been published in the Minutes of Evidence (Days 1 to 23). This Appendix contains a number of further memoranda submitted by some of these representative bodies after their oral evidence had been taken.

WHOLE-TIME CONSULTANTS' ASSOCIATION

(Day 1)

SUPPLEMENTARY MEMORANDUM OF EVIDENCE

I. PROFESSIONAL EXPENSES

(Day 1, pages 31-32 and Questions 198-237)

All members of the Association were circularised direct for details of deficit under various headings after official payment, if any, had been received. Reports were received from 144 members and the following statements are based on a detailed study of these replies.

1. Car Expenses

There are various items to be taken into consideration when reviewing deficit costs:

- (a) Size and make of car—whole-time consultants expect to run a car which costs around £1,000. A number, however, with heavy family commitments are forced to buy small cars or keep other cars beyond their normal span of life.
- (b) Whole-time consultants who live some distance from their hospitals are only allowed a home-to-hospital mileage covering emergency visits and on those days when actual domiciliary visits are carried out. In practice, it is essential to bring the car each day because it is impossible to tell in advance when a domiciliary request will be received. These doctors suffer considerable personal expense and are bitter because their part-time colleagues are allowed a home-to-hospital allowance for all visits in addition to sessional time.
- (c) The official mileage payment generally covers the running cost of the car, but does not meet the depreciation, i.e. the wear and tear factor, which is variously estimated from £150-£200 per annum, depending upon the type of car and the annual mileage. In addition, there is the capital outlay for which certain consultants are forced to borrow money. One consultant gave £45 per annum as his interest charge.
- (d) The whole-time consultant, when his car is out of commission, is not allowed the extra cost of hiring a substitute vehicle. The usual mileage allowance does not cover this extra personal expense.
- (e) When the mileage consists of a large number of short journeys, the petrol consumption is high. If, on the other hand, the journeys are long, the total mileage is high and the car wears out much more quickly. The special long-distance payment for part-time consultants is not allowed for whole-time consultants and the latter cannot see any reason why there should be a differentiation under this heading. The time factor is just as important to the whole-time consultant as to the part-time consultant.
- (f) Garage rent varies enormously. In the replies, it was variously estimated from £10-£52 per annum, and some consultants stated that they kept their cars in the street outside their homes because they could not afford to pay the high rental charge in their area.

Analysing the returns, 122 members who use their cars for their work showed a financial deficit:

£10-£50 deficit	...	...	...	33 = 27 per cent
£50-£100 deficit	...	...	...	34 = 28 per cent
£100-£150 deficit	...	...	...	23 = 19 per cent
£150-£200 deficit	...	...	...	11 = 9 per cent
£200-£300 deficit	...	...	...	21 = 17 per cent
Total...	...	...	...	122

It is interesting to record the case of one pathologist who covers the pathological service of a rural area and who is responsible for general practitioner and domiciliary work throughout that area over a radius of approximately 10 miles in each direction. He was asked by the Regional Board to purchase a car for use solely in connection with that appointment, but despite confirmation from the Regional Board that the car was essential to his work and used solely for that purpose, being required to be available at all times of the day and night, the income tax authorities would not grant any rebate. The car purchased in 1950 cost £700 and this was replaced by a car purchased in 1955 for £1,150. The annual professional mileage carried out has been approximately 10,000 miles per year. The consultant reckoned that he was out of pocket to the extent of between £200 and £300 per annum.

2. *Renewal of Instruments and Other Equipment*

Only 31 of 144 replies reported expenditure under this heading:

£0-£10	...	...	...	29
£10-£20	...	...	...	1
Over £20	...	...	...	1
Total	...	...	...	31

One person had purchased a portable X-ray apparatus at a cost of £120. Members pointed out that generally they could manage to obtain their instruments from the Hospital Management Committees, but this was often difficult as the budget item for medical and surgical equipment was frequently overspent. In practice, some members purchased the instruments required and left the reimbursement to be negotiated later.

3. *Books*

106 members reported expenditure under this heading:

£0-£10	...	...	...	79
£10-£20	...	...	...	20
£20-£30	...	...	...	7
Total	...	...	...	106

A number stated that they could not afford to buy up-to-date books and many were quite sure that they would spend up to £20 per annum regularly if there was an income allowance for this purpose.

4. *Journal Subscriptions and Scientific Society Subscriptions*

139 members reported expenditure under this heading. In 5 cases there was nil expenditure and 2 of these reported good library facilities in their local hospital:

Up to £20 p.a.	...	...	...	86 = 62 per cent
£20-£30 p.a.	...	...	...	39 = 28 per cent
Over £30 p.a.	...	...	...	14 = 10 per cent
Total...	...	...	...	139

Many members stated that they would increase their expenditure under this heading if there was a tax allowance. Fifteen reported having resigned from societies and/or having stopped journal subscriptions because of financial difficulties. Many members appreciated the value of expenditure under this heading, stating that they would increase their personal expenditure if there was a tax allowance.

5. *Preparation of Scientific Papers (including use of study room, clerical assistance, etc.)*

For most members there was negligible expense, but several estimated that they were out of pocket up to £50 for the use of a study room, up to £25 for secretarial assistance and up to £20 for the cost of reprints of articles which they had submitted. Two members actually received a regular yearly income tax allowance under this heading. In addition, it was noted that 2 members living in the same area and working under similar conditions were treated quite differently by the same income tax inspector.

6. *Stationery and Postage*

There was negligible expense under this heading, but in a few cases it was named as amounting to £10.

7. *Telephone*

119 members reported expenditure under this heading. The figure generally estimated was between £5 and £20 per annum. In some cases, however, where members were on call for long periods, either because the consultant was the only one of that specialty in the area or because he had additional responsibilities, there was a feeling of great hardship, and an expenditure of between £50 and £100 per annum was suggested to meet the cost of manning the telephone, a duty which generally falls on the doctor's wife.

8. *Expense of National and International Meetings*

Expense of Visiting Hospitals and Clinics at Home and Abroad

The figures under this heading were often nil with regrets. Many members deplored the fact that they could not afford to attend as many meetings as they felt desirable. A few enterprising individuals who had gone abroad to international congresses, etc. found that they were sadly out of pocket. One member expended £150 in one year under this heading; another spent £150 on a visit to America. A third reported that he had spent £105 on a visit to America several years ago. A fourth visited clinics in the United States, the total cost being £400, towards which he received a grant of £200 from an endowment fund, leaving a deficit of £200. A fifth visited an international congress in radiology in Mexico at a cost of £450, all of which he paid himself. Where not otherwise stated, members were granted study leave with pay, but without expenses.

Most members appreciated the value of visiting other hospitals and clinics and, if possible, of going abroad, but this is something which might quite easily fall into the holiday period. There was little encouragement to do this work if the person was separated from his family and out of pocket as well.

9. *Expense of Entertaining Visiting Colleagues*

50 members returned expenses under this heading; it was generally between £5 and £20 per annum, but in 8 cases it was over £20 per annum.

II. DOMICILIARY VISITS

(Day 1, page 32 and Questions 238-259)

Members were asked for some details of domiciliary visits carried out during a recent period of twelve months. Eighty-two gave figures as under:

32 and under	...	...	...	54	=	66 per cent
33-100	...	...	...	17	=	21 per cent
101-200	...	...	...	9	=	11 per cent
201 and over	...	...	...	2	=	2 per cent
Total...	...	...	...	82		

As requested by the Royal Commission, I have listed the consultants with domiciliary visits over 100 per year and those with less than 32 under the various specialties:

<i>Over 100</i>				<i>Under 32</i>			
General Medicine (3)	...	...	101	General Surgery	...	...	6
			119	General Medicine	...	...	7
			141	Paediatrics	...	...	3
Obstetrics and Gynaecology (1)			241	Pathology	...	...	9
				Chest Diseases	...	...	10
Chest Diseases (2)	...	...	117	Obstetrics and Gynaecology	...	...	4
			122	Radiotherapy	...	...	2
				Infectious Diseases	...	...	3
Clinical Pathology (3)	...	...	180	Psychiatry	...	...	2
			226	Physical Medicine	...	...	2
			120	Orthopaedic Surgery	...	...	2
				Venereology	...	...	2
Psychiatry (1)	...	...	155	Anaesthetics	...	...	2
Geriatrics (1)	...	...	117	Total	...	...	54

III. MOVEMENT FROM WHOLE-TIME TO PART-TIME SERVICE

(Day 1, Questions 145-154)

Summary of Changes in Regions

Whole-Time to Part-Time:

<i>Region</i>	<i>Consultants</i>	<i>S.H.M.Os.</i>	<i>S.H.D.Os.</i>
South West Metropolitan	39	4	—
North East Metropolitan	19	4	1
North West Metropolitan	25 (including 1 or 2 S.H.M.Os.)	—	—
South East Metropolitan	16	3	—
Totals	99 (including 1 or 2 S.H.M.Os.)	11	1

Part-Time to Whole-Time:

<i>Region</i>	<i>Consultants</i>	<i>S.H.M.Os.</i>	<i>S.H.D.Os.</i>
South West Metropolitan	5	—	—
North East Metropolitan	—	—	—
North West Metropolitan	—	1	—
South East Metropolitan	4	—	—
Totals	9	1	—

South West Metropolitan Regional Hospital Board, 1948-57

Whole-Time to Part-Time:

<i>Specialty</i>	<i>Consultants</i>	<i>S.H.M.Os.</i>
Surgery	14	—
Obstetrics and Gynaecology	6	—
Radiology	2	—
Radiotherapy	1	—
Physical Medicine	1	—
Anaesthetics	3	—
Thoracic Medicine	1	—
General Medicine	8	1
Orthopaedics	2	1
Plastic Surgery	1	1
Psychiatry	—	1
Totals	39	4

Part-Time to Whole-Time:

<i>Specialty</i>				<i>Consultants</i>
Anaesthetics	...	...	...	3
Pathology	...	...	...	1
Radiology	...	...	...	1
Total	...	...	...	5

There are under contract with this Board approximately 1,200 consultants and senior hospital medical officers:

				<i>Consultants</i>	<i>S.H.M.Os.</i>
Whole-Time	...	...	...	230	160
Part-Time	...	...	...	660	150
Totals	...	...	...	890	310

*North East Metropolitan Regional Hospital Board, 1948-57**Whole-Time to Part-Time:*

<i>Specialty</i>				<i>Consultants</i>	<i>S.H.M.Os.</i>	<i>S.H.D.Os.</i>
General Medicine	...	...	...	3	1	—
General Surgery	...	...	...	8	—	—
Orthopaedics	...	...	...	2	—	—
Pathology	...	...	...	1	—	—
Radiology	...	...	...	1	—	—
Chest Diseases	...	...	...	1	—	—
Anaesthetics	...	...	...	1	—	—
Obstetrics and Gynaecology	...	...	...	2	—	—
I.D. and V.D.	...	...	...	—	1	—
Psychiatry	...	...	...	—	2	—
Dentistry	...	...	...	—	—	1
Totals	...	...	...	19	4	1

Part-Time to Whole-Time:

Nil

<i>Total Number in Region:</i>				<i>Consultants</i>	<i>S.H.M.Os.</i>	<i>S.H.D.Os.</i>
Whole-Time	...	...	...	127	78	1
Part-Time	...	...	...	453	66	7

*North West Metropolitan Regional Hospital Board, 1954-57**Whole-Time to Part-Time:*

<i>Specialty</i>				<i>Consultants</i>	<i>S.H.M.Os.</i>
Surgery	...	...	...	6	—
Obstetrics and Gynaecology	...	...	...	1	—
Radiology	...	...	...	—	—
Physical Medicine	...	...	...	2	—
Anaesthetics	...	...	...	1	—
Thoracic Surgery	...	...	...	1	—
General Medicine	...	...	...	2	1
Orthopaedics	...	...	...	1	—
Plastic Surgery	...	...	...	2	—
Psychiatry	...	...	...	2	—
Dermatology	...	...	...	1	—
Paediatrics	...	...	...	1	—
Pathology	...	...	...	4	—
Totals	...	...	...	24	1

Part-Time to Whole-Time:

<i>Specialty</i>	<i>Consultants</i>	<i>S.H.M.Os.</i>
Psychiatry	—	1
<i>Total Number in Region:</i>	<i>Consultants</i> 205	<i>S.H.M.Os.</i> 99

*South East Metropolitan Hospital Board**Change from 9 notional half days weekly to whole-time:*

	1953	1954	1955	1956	1957	
Physical Medicine	—	1	—	—	—	} All Consultants No S.H.M.Os.
Radiology	—	—	1	—	—	
Psychiatry	—	—	—	—	1	
Anaesthetics	—	—	—	—	1	
Totals	—	1	1	—	2	

Change from whole-time to part-time:

	1953	1954	1955	1956	1957	Pending
Obstetrics and Gynaecology	2 C	—	—	—	—	1 C and 1 S
Pathology	1 C	—	—	—	1 C	
Radiology	2 C	1 C	—	—	—	
Psychiatry	1 C	—	1 S*	2 C	—	
Anaesthetics	—	2 C	2 C	—	—	
General Surgery	—	1 C	—	—	—	
Chest Diseases and Radiology	—	1 S	—	—	—	
Chest Diseases	—	—	—	—	1 C	
General Medicine	—	—	1 S	—	—	
Totals	6 C	4 C 1 S	2 C 2 S	2 C	2 C	1 C 1 S

C—Consultant.

S—S.H.M.O.

* This practitioner (female) changed from whole-time to 7 N.H.Ds. weekly in order to work at one clinic only instead of at two widely separated clinics. All the others changed from whole-time to 9 sessions weekly.

Additional information in respect of S.H.M.Os. has been added in case this is required.

Total for Region, 127 Whole-Time Consultants at end of 1957, 87 Whole-Time S.H.M.Os.

MEDICAL PRACTITIONERS' UNION*(Day 3)***PRELIMINARY EVIDENCE ON THE REMUNERATION OF HOSPITAL MEDICAL STAFF IN THE NATIONAL HEALTH SERVICE**

1. The staffing structure of hospitals has developed from the deep past of the history of medicine. The modern hospital has its origins and beginnings with the age of Lister and the introduction of the antiseptic method into surgery. This great advance is for ever linked with the discovery of anaesthesia in 1846 by a Boston dentist, William Morton. These twin advances opened the age of surgery as the dominant force in medical practice at the turn of the century. The hospital was moulded above all to surgical needs.

HISTORICAL SURVEY

2. The voluntary hospital developed in all large towns and more particularly in centres of university teaching, and honorary physicians and surgeons were appointed to the staff of the hospital. These doctors had full consultant status, and were later assisted by young resident doctors known as house doctors. Later still an intermediate "registrar" grade was created. Registrars were young men hoping to obtain an appointment at the hospital, and they received a small sum for keeping notes and records of their chief's patients in good and proper order. In some hospitals the term "first assistant" was used, and this is a more accurate description of their duties in recent times. Increasing development towards specialisation during the last fifty years has led to many special departments being set up at these hospitals, each under the control of a consultant with various assistants in the three main grades of Consultant, Registrar and House Officer. These special departments may be clinical—such as Cardiology or Genito-Urinary Surgery; or they may be non-clinical—such as Pathology or Biochemistry.

Dominance of Surgery

3. Surgery reached the apex of its dominance during World War I. Afterwards many Boards of Guardians who possessed Poor Law Infirmarys appointed surgeons to the staff, and some of these hospitals were gradually modernised. The legislation of 1929 allowed local authorities to develop hospitals, and those in large towns led the way. The London County Council appointed Medical Superintendents and Deputy Medical Superintendents usually with an interest alternately in medicine and surgery. The duties were partly administrative and partly clinical. These men were supported by Assistant Medical Officers—often very well qualified—who were appointed at low salaries for a period of years (usually not more than four). Elsewhere permanent appointments were given to physicians and surgeons not having administrative duties, but these cases were exceptional. The qualifications and status required were similar to those demanded for appointments to the staff of the voluntary hospitals, but the doctors appointed were paid by salary.

Cottage Hospitals

4. By the beginning of this century a number of cottage hospitals—established also by voluntary subscription—had been established in small towns in all parts of the country. The staff of these hospitals usually included all general practitioners practising within a given radius. As the extent of surgical intervention grew wider these hospitals too acquired operating theatres and an increasing amount of surgical treatment was done. Following World War I many of these hospitals were enlarged and modernised. Fully trained surgeons, some being part-time general practitioners, were appointed to the staff; others, in the vicinity of university towns, were consultants from the large voluntary hospitals. Thus in certain cases cottage hospitals staffed with general practitioners began to transform themselves into district hospitals with a full consultant staff. Cottage hospitals had no resident doctors; the general practitioners were called in by the nursing staff when necessary.

Before the War

5. Up to the outbreak of World War II, therefore, three types of hospitals with three types of staffing were found: (1) large voluntary hospitals with consultants, registrars and house officers; (2) municipal hospitals with responsible doctors doing administrative and clinical work (the equivalent of consultants) and Assistant Medical Officers with temporary or permanent appointments, some municipal hospitals having house officers as well; (3) cottage hospitals with consultants or G.P. specialists, and ordinary general practitioners. There was also the hospital in transition from cottage hospital to district voluntary hospital where the number of consultants and G.P. specialists was large and house officers of a senior type were appointed.

6. The large voluntary hospitals associated with university centres were used for teaching medical students and high standards were maintained. The admission of cases was related to the requirements of teaching and research as well as to the

special skills of individual members of the staff. There was no specific responsibility to admit a particular case to the hospital. Other large voluntary hospitals, not associated with medical teaching, had a less specialised character and tended to take all types of cases, but there was no absolute responsibility to do so. By contrast municipal hospitals had a statutory duty to admit sick people from a particular district requiring hospital attention. Thus local authority hospitals dealt with large numbers of cases without necessarily having the full medical staff required to deal adequately with every variety of sick person admitted. These two hospital systems were complementary, and although rivalry existed, they tended to support each other.

Emergency Medical Service

7. This system provided a very good service in some parts of the country but there were many gaps. World War II brought into existence the Emergency Medical Service which unified all the hospital resources of the country. The staffing was by a mixture of voluntary and municipal methods. A medical administrator was appointed in each case. Physicians and surgeons from voluntary hospitals undertook part-time duties which were paid. Registrars and house officers were mostly resident and all paid, except for some student house officers. These hospitals were available at all times for air-raid and service casualties as well as civilian cases. The distinction between a registrar and an assistant medical officer was obscured. Appointments in both these categories were reserved from military service and were made annually. A few assistant M.O. and senior house officer appointments were reserved for six months. Junior house officers were reserved for six months.

8. After the war some doctors leaving the services without appointments were given supernumerary registrar appointments at hospitals in all parts of the country. Thus the number of registrars was suddenly increased. There did not seem to be any clear policy other than to find posts for doctors leaving the services. The effect of these arrangements was to improve staffing in many hospitals and the standard of service given to the patients rose to a new high level. When the National Health Service commenced in 1948 many assistant medical officers at local authority hospitals were graded as registrars. Some senior ones were designated consultants, others S.H.M.O.s and a few J.H.M.O.s. The number of registrars after one year of the N.H.S. was very large. The supernumerary registrar posts were subsequently abolished and Regional Boards at once created numerous registrar posts to absorb displaced registrars. Gradually new consultant posts were created and after 1950 new S.H.M.O. appointments were made in some specialties. This process, together with drastic cuts in the senior registrar grade, led to a steady upgrading of hospital doctors into higher grades. From about 1951, however, the process was brought steadily to a halt, so that in recent years few have been able to advance beyond the point reached at that time and prospects for the registrar have become increasingly hopeless and obscure.

Reorganisation of Hospitals

9. The take-over of a wide variety of hospitals in 1948 was accomplished with remarkable smoothness. The Voluntary Teaching hospitals were accorded a special status under the National Health Service Act. This status allowed them to retain the major part of their former independence and funds, while receiving grants from the Treasury. Many non-teaching hospitals were added to these teaching hospital groups. The non-teaching large voluntary hospitals and the municipal hospitals in big towns became local area hospitals under Regional Hospital Boards and development was continuous. In smaller towns having hospitals in transition a period of reorganisation followed. General practitioners were excluded from these hospitals in many cases—some were appointed as consultants under the N.H.S. and gave up general practice; some remained as part-time S.H.M.O.s on the staff of the hospitals; others were excluded. Where former cottage hospitals were not developing into major hospitals in this way, many continued to exist as general practitioner hospitals under the N.H.S. In other cases these general practitioner hospitals have been closed down and the accommodation used for special units attached to the local area hospital. General practitioner hospital units have suffered a severe set-back under the N.H.S. but

the teaching hospitals associated with the universities have achieved a position of great power and prestige, and stand without rivals at the pinnacle of the hospital scheme.

10. This position of eminence is proper to the great centres of teaching and research. The loss of independence both as regards staffing arrangements and capital expenditure which has been the common fate of all types of hospitals transferred to the Regional Hospital Boards in England and Wales is to be regretted. Thus has developed a two-tier hospital service in which the upper tier is not given specific responsibility for patients in its own area, while the lower tier must accept full local responsibilities without the power to make provision for needs which it cannot fulfil. Some restoration of the former balance is important.

After the War

11. The outbreak of World War II marked the opening of the modern era of medical practice—the age of chemotherapy or chemical treatment. New chemical substances with specific and potent effects on the body processes have been rapidly introduced into medical practice on a truly massive scale. While in one sense this has reduced the field of surgery, in another it has permitted surgeons to tackle and solve ever more difficult problems at the cost of ever-increasing specialisation. General practitioners can use new chemical agents on patients at home but if initial treatment fails, complex problems needing full hospital investigation often remain, and in hospital the care of a single medical specialist is often not enough to solve the problem. Increasingly one or more of the various types of pathologist (bacteriologist, morbid anatomist, haematologist or biochemist) must be called into consultation with one or more specialists in the clinical field. The medical physicist and mathematician will very soon be required to handle the complexities of modern therapy. There exists, therefore, a very great need for a planned expansion of medical staffing at all area hospitals under the N.H.S.

HOSPITAL STAFFING—GENERAL CONSIDERATIONS

12. Any consideration of remuneration of hospital medical staff must, in the Union's view, be related to responsibilities undertaken by different grades of medical staff, conditions of work, prospects for promotion and other factors. To fix salary scales appropriate in 1958 solely by reference to the findings of a committee which had no foreknowledge of how the new Service was to develop would be unrealistic. Ten years of the National Health Service have created new circumstances which demand new solutions. The main purpose of this preliminary memorandum therefore is to examine in detail the present medical staff structure of the hospital service with special reference to those factors related to remuneration.

13. To do this, however, requires accurate information regarding the present staff structure of the hospitals. In this the Union, like other bodies giving evidence and the Royal Commission itself, is handicapped by a lack of figures. There is no uniform pattern to which one can refer. Hospital staffing arrangements vary widely according to the type and size of the hospital, proximity of other hospitals, the degree of specialisation and other factors. It is scarcely possible to make any general statement with regard to the hospital service which cannot immediately be challenged by quoting specific exceptions. Nevertheless the Union believes that there are certain general valid observations that can be made on the present organisation of hospital staffing. In the following paragraphs we describe some of the faults of the present hospital service which exist and which need to be rectified if a sound basis of remuneration is to be established.

Variability of Hospital Staff Establishments

Lack of Uniformity

14. When one remembers that the National Health Service took over all types and sizes of hospitals in 1948 and that little uniformity existed before that date with regard to staffing it is not surprising that wide discrepancies are found even to-day in the staff structure of hospitals within the Service. The Union would

have liked to have provided comparisons involving many hundreds of hospitals. Unfortunately there are inadequate statistics on which to base comparisons. Nevertheless it is clear from the evidence received by us that there is no uniformity in the present staffing arrangements in the hospital service. The number of beds looked after by consultants and the number of out-patients seen by each vary widely not only between hospitals but within the same specialty. Indeed we have been shown examples of two hospitals in the same part of the country, serving the same general function, with approximately the same number of beds and with a similar load of out-patients, having very different staff structures.

15. In Appendix A examples are given of consultant staffing in various hospitals of a similar type.

16. Some years ago (1951) the Ministry of Health recognised the need to investigate hospital establishments throughout the country. It set up separate working parties to investigate the position in each region. No report has appeared of the findings of these working parties nor is there any evidence that material alterations were effected following any report. The Royal Commission might with advantage ask the Ministry of Health for the results of these enquiries.

17. The Union believes that the present discrepancies in the hospital medical staff establishments should be rectified. There may be some hospitals where the number of consultants under contract is sufficient to enable all patients to be seen by a consultant. In many the number of consultants is so few that a large burden of the work falls on the junior staff. This gives rise to dissatisfaction among the medical staff employed and means in fact that the public in some areas are not receiving the quality of service they might expect.

Medical Grading Anomalies

18. Owing to the shortage of consultant staff much of the work of the hospital service which should properly be done by consultants is undertaken either by senior hospital medical officers or by junior hospital staff under training.

Many senior hospital medical officers are undertaking full consultant responsibility while others work under purely nominal supervision. Many senior registrars are similarly placed. From the public viewpoint it matters little that these two grades are misused, for both include men and women of the highest medical training. However, from the viewpoint of the doctors concerned the result is that they are called upon to undertake considerable responsibility for much lower remuneration.

19. There is overwhelming evidence that junior staff at all times are being required to undertake work of a responsible character. The Union has received evidence from individual hospitals which clearly demonstrates that much major and minor emergency surgery is undertaken by doctors within a few years of qualification. The Union is sure that much of the work ought to be performed by consultants but cannot be as long as their number is insufficient. The Union believes that junior medical staff under training should not be permitted to undertake major clinical responsibility without supervision.

The Need to Establish General Principles for Hospital Staff

20. When the Service came into operation the Ministry of Health published a document, *The Development of Consultant Services*, to "assist Regional Hospital Boards in the planning and future development of the consultant services". Suggestions were made as to the number of consultants needed, in terms of the population served, for all the main specialties. The decisions with regard to establishments are the responsibility of the Boards themselves. Each Board, however, is required to work within a rigid financial framework which determines to some extent its decisions. Another major factor is the attitude of the existing consultants. Additional consultant appointments are made not on theoretical considerations but because of local pressure for increased staff. The initiative comes from the hospital management group and this in turn will be influenced by the attitude of the existing consultants in each specialty who are often unenthusiastic about the creation of new consultant posts.

Shortage of Consultant Staff

21. The number of consultants in the hospital service has risen from 5,592 in December, 1949, to 7,244 in December, 1955. There is no reason, however, to think that the expansion of this grade is at an end. Indeed, the Willink Committee have allowed for an annual expansion of 160 over the next seven years and for further expansion after that time of 80 a year. The Union believes that the present number of consultants is insufficient to staff the hospital service adequately. The reasons for this conclusion are as follows:—

- (1) It is clear that much of the routine hospital work of a responsible character is now being undertaken by junior hospital staff. To avoid this more consultants are required.
- (2) The number of senior registrars and S.H.M.O.s at present undertaking consultant responsibility is large. If, as the Union later recommends, many of these senior doctors are to be included in the consultant grade more consultant posts will have to be created.
- (3) The Ministerial forecasts of the consultant needs of the service given in the 1948 Blue Book do not appear to have been fulfilled. For instance, they estimate that three whole-time consultants (or the equivalent in part-time) are needed in the field of general medicine for 100,000—120,000 of the population. This would mean about 1,400—1,500 consultants in this field. The actual number is under 1,000.

In Appendix B figures are given of the numbers of beds and senior hospital staff in the main specialties.

22. Without a close study of the work of each hospital it is difficult to estimate how many additional consultants would be needed. The number is probably not less than 2,000. The necessary expansion of the consultant establishment could take place quickly as there is a large pool of doctors of proven or potential consultant status available for promotion. Apart from S.H.M.O.s and fully trained senior registrars there are many other experienced doctors working in the medical schools and research establishments. The opportunity for a rapid expansion may not come again for many years. In order to give the public the benefit of a proper consultant service, to avoid misuse of hospital medical staff and to provide a reasonable avenue for promotion, it is essential that the number of consultants should be materially increased.

Uncertain Prospects for Hospital Staff

23. The National Health Service cannot be organised so as to provide certain prospects of promotion to the highest level for all doctors. Nevertheless it is in the public interests and in the interests of the profession that doctors entering into a public service should have reasonable prospects of rising to posts of higher responsibility if their talents and training warrant it. This is especially so in the case of the hospital section of the Service because there are so few opportunities outside the Service itself for employment. The Union recognises that the number of doctors to be employed must depend first and foremost on the needs of the hospital service. Posts cannot be created merely to provide opportunities for promotion. Nevertheless the numerical relationship between the junior and senior staff must be carefully determined in order to avoid wastage of medical manpower. One of the most constant criticisms levelled at the hospital staffing organisation is that junior doctors have been trained in the anticipation of promotion within the Service without any opportunities being provided for continuing work within the Service. After the war large numbers of supernumerary registrar posts were created to absorb doctors leaving the armed forces. The result of this was to create a bottle-neck in promotion. To-day the chances of promotion for registrars or senior registrars are very poor.

24. Many S.H.M.O.s are also entitled to expect that they will be promoted to consultant status. These hopes under present circumstances will be frustrated.

25. The Union believes that any doctor who has passed through his preliminary training period and has been accepted as having the necessary attributes to work permanently in the hospital field should be offered reasonable prospects of promotion to consultant status.

Relationship Between Hospitals and General Practice

26. When the National Health Service was brought into being a tripartite system of administration was introduced. This led to an ever-widening gulf between the hospital service and general practice. It is increasingly difficult on the one hand for hospital medical staff to find openings in general practice and on the other for general practitioners to play a useful part in the hospital service. The Union believes this trend is against the best interests of medicine and would welcome any measures for bringing the two branches of the Service closer together.

Short-term Appointments

27. The junior posts in the hospital service are almost entirely short-term. House officers are appointed for six-month periods; registrars for periods of two years (with annual review) and J.H.M.O.s in some cases for limited periods. The Union does not wish to criticise these arrangements in general. It must be recognised, however, that the doctors concerned are often financially handicapped by a succession of short-length appointments. Changing appointments involves them in a great deal of expense. When they are married they may have to maintain two establishments. The Union suggests that these factors should be taken into consideration when determining their remuneration.

Consideration of the Hospital Grades

28. Many of the problems of hospital medical staff are common to all grades. There are, however, some special problems connected with each grade. The Union sets out below some of the particular complaints of each grade.

House Officers

29. The post of house officer is the first held by a practitioner after provisional qualification. He has by law to do two appointments in order to get finally registered, but in many instances will take on one or more six-monthly appointments following registration. In the opinion of the Union these posts should be remunerated at a higher scale (higher absolutely and relatively to other grades) than they are at present. At the present time the most junior post carries a salary of £467 10s. 0d. p.a., from which must be deducted board and lodging of £125 p.a. Even the senior house officers receive only £819 10s. 0d. p.a., less £150 p.a., for board and lodging charges. Many of these house officers are undertaking very responsible duties. The Union will in its final memorandum make recommendations to the Commission as to the actual rates of remuneration which should be introduced.

30. The particular difficulties encountered by house officers are as follows:

- (1) The married house officers are seldom provided with married quarters and may therefore have to maintain two homes.
- (2) Since the appointments are for six months only in most instances the young doctor may encounter a period of unemployment between appointments.
- (3) The cost of moving from one appointment to another is not inconsiderable and no allowance is made for this in the salary scales.

Registrars

31. The registrar grade more than any other tends to be misused. In the regional hospitals registrars are frequently required to carry a big load of responsibility and in the absence of their consultant chiefs at night or at week-ends must often undertake procedures for which they are not fully trained. The road to promotion is very difficult, even where the suitability of the applicant is unquestionable. The registrar in the regional hospital has a very small chance of promotion as compared with his colleague in the teaching hospital.

32. In some posts where no residential accommodation is available the young doctor is given to understand that he must have a motor car so as to be on call in case he is required. Possession of a car may affect his chance of appointment. The

shortage of married quarters is an even graver handicap to the registrar than to the house officer because being older he is more likely to be married and to have children.

33. The Union has had many individual instances of hardship in the registrar grade brought to its attention. The following is a quotation from one communication received:—

"... In a large regional hospital in the North-west Metropolitan Region a surgical registrar, aged 32, married and with two children (M.B. 1946, F.R.C.S. Eng. 1954), has held registrar appointments since 1949 in surgery and is at present attached to a genito-urinary and general surgery firm. He has held this appointment since November, 1954. He does all the emergency surgery and a considerable share of the "cold list" cases, out-patients, cystoscopy and other clinics. He deputises for the consultant when he is absent on leave and carries on the work of the department normally during his absence.

He is on duty 82 hours per week and works an average of 61. The salary for this post (before the 10% increase) was £18 11s. 0d. gross per week. He receives no car or telephone allowance and no allowance for books, membership of learned societies, etc. He has unsuccessfully applied for more than 30 senior registrar posts in the last 18 months. It is becoming increasingly difficult for non-teaching hospitals to obtain registrars as they see no possibility for further promotion if they accept these appointments. There is no security of tenure and little hope of obtaining a higher grade appointment."

This surgeon has since emigrated to Australia.

34. From the quite considerable amount of evidence offered to the Union it is clear that the above instance is not exceptional.

Junior Hospital Medical Officers

35. The grade of J.H.M.O. was created to absorb a number of full-time medical officers who worked in a subordinate capacity in the old county hospitals, mental hospitals and chest hospitals. More recently it has been used to attract senior house officers for a term longer than one year at a higher rate of pay. It was always assumed that the grade would in time die out, yet some new appointments are still being made. Many carry a level of responsibility not warranted by their training and not reflected in their remuneration.

Senior Registrars

36. Owing to the disparity between the number of senior registrars and vacancies in the consultant establishment they have no assured future in the Health Service; they have great difficulty in entering general practice and little opportunity for private hospital practice. When it is remembered that many senior registrars are in their mid or late 30's, married, with children, have the highest possible qualifications and many years of the most responsible work behind them it is not surprising that as a group they feel very frustrated.

37. Even those senior registrars who eventually obtain a consultant appointment do so at a far later age than that intended by the Spens Committee. This delay is reflected in lesser total life earnings. The same problems with regard to the expense of moving and the lack of provision of married quarters mentioned above apply to senior registrars. Many senior registrars are "time expired," i.e., they have carried out their normal 4-year course of duty and are being kept on without any increase of salary. The choice of senior registrars for consultant appointments appears to be influenced to an unwarranted extent by their contacts with teaching hospitals. Senior registrars carry a very high level of responsibility and much of their work is carried out without supervision. The longer the senior registrar remains in the hospital service (i.e., the greater the degree of specialisation) the less are his chances either of obtaining a consultant appointment or of securing an opening in general practice.

Senior Hospital Medical Officers

38. The S.H.M.O. grade was never envisaged by the Spens Committee. It was devised as a provisional grade for certain medical officers from local authority hospitals and for other doctors having limited qualifications and experience in a

narrow field. Yet now, after ten years of the N.H.S., there is one S.H.M.O. for every three consultants. An attempt was made in 1950 to limit new appointments in this grade by the terms of Ministry Circular R.H.B. 50/96. Despite this the number of S.H.M.O.s has increased steadily since.

39. Many doctors now graded as S.H.M.O. were in fact carrying out medical work of full clinical responsibility before the Service began. They feel that they are now relegated to a secondary status, to say nothing of their diminished earning power.

40. It is difficult to assess what proportion of S.H.M.O.s are carrying full consultant responsibility but it is probably a high one. Indeed there are few S.H.M.O.s to-day who regularly work under the supervision of a consultant. Despite the diminished status of the S.H.M.O. advertisements in the medical journals for S.H.M.O. posts normally require the highest qualifications. In competition with younger applicants of senior registrar status, the S.H.M.O. finds himself in a position of inferiority. The grade is increasingly considered to be a dead end one with little hope of advancement to consultant status. The few S.H.M.O.s who do eventually attain consultant status are usually over 40 years of age.

41. The Union believes that the S.H.M.O. grade has been misused by the Ministry of Health and by the Regional Hospital Boards, particularly in some specialties. R.H.B. 50/96 designated the specialties in which S.H.M.O.s might be appointed. Since the circular was issued there has been a 30% increase in S.H.M.O. appointments in these specialties compared with a 17% increase in consultant appointments. This is due in part to Ministerial policy and in part to the reluctance of the profession to ask for more consultant posts.

42. Despite the small difference of real responsibility carried there is a very large discrepancy in the earnings of S.H.M.O.s and consultants. Assuming appointment at the age 32 in both cases, the consultant earns £34,000 more than his S.H.M.O. colleague by the time he is 65 years of age, and this does not take into account remuneration by distinction award, private practice or earnings from domiciliary visits. The salary scales of the two grades are so adjusted that the man newly appointed as consultant earns more than the S.H.M.O. specialist of ten years' experience. Prior to the 1954 award there was an overlap between the two scales.

The Consultant Grade

43. Leaving aside the level of remuneration which will be dealt with in the Union's final memorandum, the anomalies in the consultant grade centre chiefly around the relation of whole-time and part-time employment.

44. The advantages of part-time employment are so great that the tendency is more and more to seek such contracts. The Union does not wish to argue the merit of whole-time and part-time employment in general terms. There is certainly a place for both in the Hospital Service at the present time. Geographical considerations and other factors (particularly in some specialties) sometimes lead a consultant to choose a whole-time appointment. Yet there are many whole-time consultants who are driven to move over to a part-time basis in order to secure the advantages which the part-timers possess. These advantages may be listed as follows:—

- (1) The part-time consultant normally undertakes some private practice; he can thus obtain from the income tax authorities the right to claim a proportion of his expenses as tax-free. This the whole-timer cannot do.
- (2) The whole-time physician has to give eight domiciliary consultations free of charge each quarter before he is eligible for the normal rate of remuneration.
- (3) The part-time consultant is credited with up to a maximum of half an hour each way to and from his main hospital in relation to all his paid sessions. He obtains payment of his travelling expenses to and from home to a maximum of 10 miles each way. The whole-timer rarely does.

(4) Another advantage obtained by the part-timer is in the method of calculation by which the total number of hours per week worked is converted into notional " $\frac{1}{2}$ days". By this system of "weighting" the part-timer gains materially.

45. The Union is in agreement with the finding of the Guillebaud Committee on this subject, particularly with the following paragraph:—

"We are also of the opinion that it is undesirable that the financial arrangements relating to the consultant service should be such as to provide a financial inducement to a consultant to apply for a part-time rather than whole-time appointment."

46. The Union wishes to draw attention to a particular staffing anomaly inherited from the past whereby some consultants hold as many as sixteen sessions although they cannot be paid for more than nine. This is due in part to reckoning travelling time as clinical time and leads to inadequate staffing. (See Guillebaud Committee Report, section 401 (vi).) The M.P.U. believes that the continuation of these arrangements is unsatisfactory, especially when there are many doctors seeking promotion.

DISTINCTION AWARDS

47. The Union would like to offer some observations on the system of distinction awards as at present operated.

48. The Spens Committee in recommending such awards made the following observations:—

"... It appears to us that this method of securing differentiation would not only maintain a proper proportion of the higher incomes, but would have the advantages of providing sufficient incentives to stimulate effort and encourage initiative; of holding out opportunities of higher reward to all specialists alike, in whatever branch of Medicine they practise; and, by throwing these awards open to specialists in all hospitals, of making it possible to maintain equality of status between hospitals and encourage a proper distribution of specialists..."

49. The purpose of the scheme was therefore two-fold: to ensure (i) that a small proportion of the profession received higher salaries "to maintain the position of British Medicine in a competitive market" and (ii) that "specialists must be able to feel that more than ordinary ability and effort receive an adequate award".

50. The method of application of the system has been open to criticism on the grounds of its secrecy. It would be wrong to say that such criticism emanates solely from the non-recipients of awards. There is, in the Union's view, serious objection to dispensing large sums of public money without any control being exercised. The distribution of awards should be equitable not only as between individuals, specialties and regions, but as between doctors who work in the regional hospitals and teaching hospitals. No one knows whether this distribution is, in fact, equitable. It is this ignorance which is the basis of valid criticism. The sole argument of any substance in favour of secrecy is that it avoids giving advantages for private practice to those known to receive the awards. The Union does not accept this argument for it assumes that the general practitioner selects a consultant on the basis of his earnings. If it is wrong for the family doctor to know which consultant is most highly paid then it is also wrong for a consultant to be granted a knighthood or barony.

51. Secrecy should be abolished. The "honours list" should appear each year in the medical press. The distribution of the fund would then be open to the scrutiny of the profession. Justice would not only be done (and we have no evidence that it is not done now); it would be seen to be done.

Objects of Fund

52. Since there were two objects in creating the Distinction Awards Fund it is proper to consider each separately.

53. If it is desired to pay a small proportion of consultants relatively large sums "to maintain the position of British Medicine" then there should be no difficulty in selecting the recipients. The professors of medicine and other specialities at our universities are obvious candidates; so, too, are the leading consultants attached to the teaching hospitals. Apart from these eminent doctors other obvious candidates would be senior physicians and surgeons of the large regional hospitals and the consultant chiefs of certain specialist departments known to be doing good work. It is reasonable to assume that most of these doctors already receive distinction awards. If this is the case—and the Union is in no position to check it—there would seem no objection in future to attaching the distinction award to the post rather than to the named individual and the Union recommends that a substantial part of the present Distinction Award Fund should be allocated in this manner. To prevent rigidity there should be an annual review of posts so as to ensure that growing hospital departments of importance are reassessed and brought within the scheme.

54. The other object is to recognise work of outstanding merit and it appears right that a proportion of the Fund should be devoted to this purpose. The Union would make the following proposals in this connection:—

- (1) That approximately one-third of the present Fund should be devoted to granting distinction awards to named individuals on a basis of merit.
- (2) That the present Committee should continue to function for this purpose.
- (3) That the Committee should invite nominations for these awards by organisations competent to assess the merit of doctors' work. Among these should be the Local Medical Committees.
- (4) That the Committee's awards should be published in the medical press and that an analysis should be given of the distribution of these awards among hospitals, specialities, etc.

THE FUTURE STAFFING OF HOSPITALS

55. In an earlier section of this memorandum the Union has shown that the responsibilities laid upon all grades up to and including S.H.M.O.s are frequently greater than their remuneration warrants. This situation can be corrected only by insistence on a proper allocation of duties as between the different grades.

56. To avoid the misuse of hospital staff and to ensure an adequate standard of medical care for the patient a complete review of existing hospital establishments is necessary. It is the view of the Union that this should be done by a Committee appointed for the purpose under a chairman who is independent of the medical profession but has some experience of hospital administration. A lawyer having this necessary experience would be a suitable person.

Teaching Hospitals and Regional Hospitals

57. The teaching hospital employs $2\frac{1}{2}$ times as many doctors as does the regional hospital for the same number of beds. Teaching hospitals are academic institutions responsible for research and for teaching medical students and nurses. Their case for a high staff ratio was quickly conceded when the N.H.S. was introduced. The regional hospital boards, in comparison, were slow to press their claims.

58. Where the ratio of $2\frac{1}{2}$:1 is a reasonable one could be ascertained only by an exhaustive analysis of the work undertaken in each type of hospital. The Union does not favour a reduction in the staff establishments at the teaching hospitals; it is inclined to the view that a disparity of staffing is an indication of the inadequacy of the establishments of the regional hospitals, many of which are in need of a substantial increase in the number of doctors in a wide range of specialities. It must be remembered in this connection that regional hospitals have to handle most of the emergency admissions in the country.

59. Regional hospitals include a great variety of institutions providing in-patient care. At one extreme there is the large all-purpose hospital with 1,000 or more beds and with whole blocks devoted to the care of the chronic elderly sick; at the other the small district hospital or specialised institution with 20-30 beds.

60. Clearly no general pattern of hospital staffing could be applied rigidly. Each type of hospital must be provided with the staff suitable to its needs. An independent review of existing hospital staff establishments is urgently required.

61. It is not possible to discuss the range of remuneration of hospital medical staff without reference to the responsibilities incurred or to the volume of work undertaken. The M.P.U. therefore has considered hospital staffing and doctors' pay as being closely connected.

A Planned Policy for Hospital Staffing

62. The present medical staffing arrangements in the National Health Service are not the result of thought and planning for the needs of the Service. While recognising that it would have been wrong in 1948 to impose a new and alien staff structure, theoretically determined and without roots in the past, it is surprising to note how little consideration was given to adjusting the inherited pattern to the needs of a new comprehensive service. Two results of this lack of foresight are the emergence of the registrar problem and the use of the S.H.M.O. and J.H.M.O. grades in a manner not originally intended.

63. Nearly ten years' practical experience of the N.H.S. now lie behind us. Modification of the present staffing arrangements must take into account certain fundamental principles. They are:—

- (1) A staff structure must be designed to provide an efficient service to the patients.
- (2) It must use the capacities of the individual doctor to the full but should not require him to undertake duties for which he is not trained.
- (3) It must provide opportunities of training with increasing experience to all those who embark on a career in the hospital field.
- (4) It must provide suitable training for all those junior staff who intend to practise in other spheres of medicine.
- (5) It must provide security of tenure at an appropriate salary for all those who are accepted as being suitable for work in the hospital field.
- (6) It must provide reasonable prospects of promotion to all medical men and women who choose a hospital career and are regarded as having the necessary attainments.

64. The existing staff structure ignores many of these principles as we seek to demonstrate in this memorandum. Hospital staff establishments are often unrelated to the needs of the public in a given area; in some hospitals S.H.M.O.s, senior registrars and registrars have to carry out duties which should more properly be undertaken by consultants. The patient or his general practitioner may feel he has been badly served by the national hospital service when consultant opinion is not available.

Existing Staff Structures

65. At present the following doctors are employed in the hospitals:—

						<i>Per cent</i>
Consultants ...	...	...	...	...	7,420	36.7
S.H.M.O.s ...	...	...	...	...	2,610	12.8
Senior Registrars ...	...	...	...	...	1,176	5.8
Registrars ...	...	...	...	...	2,822	13.9
J.H.M.O.s ...	...	...	...	...	806	4.0
House Officers and Senior House Officers	...	...	...	...	5,449	26.8
					<u>20,283</u>	<u>100.0</u>

(In addition there are G.P.s who work as clinical assistants in the hospitals.)

Junior Hospital Medical Staff

66. The junior medical staff (except some J.H.M.O.s) hold temporary appointments. Most regard their stay in hospital as training for work in other spheres. Yet they fulfil a function which is vital to the efficiency of the hospital service.

They are responsible under supervision for much of the day-to-day care of patients. The more senior among them, e.g. senior registrars of 35-40 years, carry a substantial amount of responsibility.

67. The routine work in the hospitals cannot be adequately carried out by the present number of junior staff. There are 770 junior hospital posts at present unfilled. The Willink Committee considered that this gap would be filled (a) by "some of the younger doctors staying longer in the hospital service" and (b) by "an increase in the extent to which general practitioners undertake part-time work in the hospitals."

68. The Union would like to make additional proposals. Young doctors will not wish to remain longer in the hospital service unless the remuneration in the junior grades is increased very substantially. Apart from remuneration the question of providing improved living quarters, including married quarters for resident doctors, will have to be tackled more seriously.

69. General practitioners are seldom in a position to carry out the full duties normally assigned to junior medical staff. However, proposals are submitted in a later section for using the services of G.P.s to a greater extent as clinical assistants to consultant staff of the hospital.

70. The two Willink recommendations are interrelated. Young doctors will not wish to spend much time in the hospitals unless they can look forward to using their specialised experience when in general practice.

The J.H.M.O. Grade

71. The J.H.M.O. grade presents considerable difficulties. It was created to absorb a number of full-time medical officers in the old county hospitals, mental hospitals and chest hospitals who were making a career in these hospitals in a subordinate capacity (but with some prospects of advancement) and whose duties were not sufficiently important for them to be regarded as senior medical staff. It was assumed that this grade would in time die out. More recently the grade has been used to attract senior house officers for a term longer than one year at a higher rate of pay. Some new appointments are being made. The new posts are usually temporary, and present no special problems. But the future prospects of those who have been put in this grade for their whole career are unsatisfactory. Although the number involved is small, there is no reason for the continued neglect of this section of the hospital medical staff. The Union has been unable to arrive at a satisfactory conclusion for the future of this grade which seems to contain a small number of forgotten doctors not powerful enough to make their voices heard through the general clamour for recognition and having no special claims as have the S.H.M.O.s and senior registrars. Two points of view have been expressed:—

- (1) That the grade should be retained for a certain limited purpose—possibly under a new name—and that fresh appointments should be made from among registrars who wish to stay on and work in the hospital field but are either not of the calibre or have no wish to become consultants. There should be a rising salary scale, not reaching consultant level, and complete security of tenure.

Arguments against this proposal are as follows:—

- (a) The Ministry and Boards might be encouraged to use this grade excessively for the purpose of economy. The experience of the last eight years tends to reinforce this argument.
 - (b) It might lead to the retention of an undue number of registrars.
- (2) The alternative view is that no fresh appointments should be made to this grade and that the holders of existing posts should have an opportunity for regrading according to the nature and quality of the work performed. Ultimately the grade would die out.

On balance the Union inclines to the first view, providing that assurances were given that the grade would not be misused.

A Minimum Salary for Hospital Medical Staff

72. The Spens report recommended that "Intending specialists should not be called upon to pass through a state of comparative penury . . ." It was recom-

mended that junior hospital staff (Grade III) should receive a salary of £600 a year in 1939 values of money. This, we estimate, would be equivalent to something in the neighbourhood of £1,500 a year to-day. In fact the senior house officer receives £819 10s. 0d. The Union is not concerned at this stage to recommend actual scales of pay for the different hospital medical staff grades. But it maintains that young doctors should be able to work in the hospital field for several years without facing acute financial anxiety. Many of these doctors, who are 25 to 30 years old, are married and have a home to maintain. They should not be driven out of the hospital field in order to earn a reasonable income quickly elsewhere because of the low salaries now offered by the hospitals.

Senior Hospital Medical Staff and Senior Registrars

73. At some point one must draw a line between those who regard their stay in hospital as a preparation for work elsewhere and those who wish to make a career in the hospital service. Such a line is now drawn between the senior registrar and the consultant (or S.H.M.O.). No senior registrar, whatever his age, his experience or his degree of specialisation and responsibility has any security of tenure in the hospital service. This is a grave injustice to those who have spent years preparing themselves for a career in the hospital service and a serious national waste of trained medical and surgical manpower. The Union has encountered many cases of senior surgical registrars of 38 and 40 years with the highest degrees who have been undertaking major surgery unsupervised for several years and who fail to secure consultant posts not because they are unfitted but because the posts are not available. Such cases are found in all specialties. The specialised background of these doctors prejudices their chances of obtaining any opening in general practice. This is clearly wrong and wasteful.

74. The Union suggests that the line between the training and career grades has hitherto been wrongly drawn. It is after two years as a registrar (or more in certain specialties) that the decision should be taken as to whether a doctor is fitted to follow a hospital career. If necessary an additional year should be taken as a registrar to gain the required experience. After a doctor has been appointed as a senior registrar he should have security of tenure subject to a satisfactory report some time during the second year.

The Training of Registrars

75. A clear distinction has to be drawn between the two purposes of the registrar grade—the training of consultants and the carrying on of the work of an area hospital. The number of registrar appointments made must have a well defined statistical relationship to the number of consultant posts likely to be available in six to eight years' time, allowing for an agreed percentage wastage. This wastage need not always be total as some of these ex-registrars would qualify for G.P. clinical assistantships later. At present the appointment of registrars is related mainly to the need to arrange for the care of patients. Many of the posts are admitted to be without prospects for the future. The continued use of registrars as part of the normal staff structure of every regional hospital should cease. Indeed its continuance will lead to understaffing of these hospitals as prospects for a career as consultant further diminish and visitors from overseas begin to use their own countries' growing facilities for further experience. The present close relationship between the care of patients and the availability of registrars is a weakness in the staffing of regional hospitals. If these posts are taken out of the main staffing structure it could lead to greater flexibility in the adjustment of numbers in each specialty to meet the constantly varying requirements without at the same time creating difficulties in arranging for the care of patients.

76. Certain hospital departments in each region should be designated as departments for the training of registrars and senior registrars and these hospitals should plan to train an agreed number of registrars and senior registrars in conjunction with the teaching hospitals in that region. The staffing of these specially designated hospital departments should be generous in relation to the work, as the training of a registrar or senior registrar consumes additional time of the consultants; further, registrars must be allowed time to read, to attend demon-

strations and discussions and to carry out original research. In the non-designated hospital departments all clinical work would be undertaken by senior and junior consultants with the help of resident house officers and clinical assistants from general practice.

77. In making these proposals the Union is aware that the transition would need to be gradual. The new staffing arrangements require for their success an adequate number of consultants and suitably trained general practitioners.

The Consultant Grade

78. The need to increase the senior medical staff at regional hospitals will be greater than at present if registrars now doing a large part of the work are either withdrawn or put on a less than full-time basis. A number of hospital teams (in some specialties) already have two senior medical staff, one consultant and one S.H.M.O. Every major general hospital requires at least two teams in general medicine and in general surgery and sometimes three or more teams are necessary. Each team should consist of two senior medical officers of consultant status: a senior consultant and a junior consultant. The senior consultant would do more out-patient work, have more beds for routine admissions, and advise his junior colleague when required. The junior consultant would be on call for most of the emergency work when the team was on emergency duty and he would do fewer out-patient sessions. His relationship with his senior colleague would be much the same as that of partners in general practice; each would cover the other for annual leave and special leave, as necessary. Every major specialty would require at least one team of two consultants, while in some cases only a senior consultant would be required for specialties not providing sufficient work for a fully staffed team.

The Relationship between the two Consultants within the One Consultant Grade

79. The present nine-point salary scale might be replaced by one of fourteen points. The junior consultant would start on point one (80 per cent. of the present bottom point) and proceed by eight annual increments to point nine and then by five triennial increments to point fourteen. Thus a junior consultant starting at the age of 30 would get to the top point at the age of 53.

80. The senior consultant would start on point six and proceed by eight annual increments to point fourteen. Thus a senior consultant obtaining promotion at the age of 35 would reach the top point at the age of 43. Promotion from junior to senior status would be by open competition, and on promotion the promoted junior consultant would proceed to the next point above on the scale and proceed upwards on the scale at the senior rate. Promotion should have regard not only to clinical skill and the capacity to give sound advice, but to administrative abilities which are required in many senior posts.

Seeking Promotion to Senior Consultant Posts

81. Once established the junior consultant would be free to develop his hospital work and to make his career in hospital medicine. He could also undertake private practice if part-time, and domiciliary consultations.

82. After a number of years a junior consultant might develop a large share of goodwill at a given hospital. Should he obtain a senior post at another hospital he could lose most of his income from private and domiciliary consultations. He would, however, gain an increased rate for his hospital duties, and an improvement in his status. Thus promotion would be sought after by good men. Those who were unsuccessful or who decided not to seek senior status would not necessarily lose much financially if they made the necessary effort in other directions. Flexibility would thus be introduced into the hospital service. Merit awards should be open to all consultants as at present.

The S.H.M.O. Grade

83. The appointments of S.H.M.O.s should be reviewed in relation to the work done. They should either be regraded as senior or junior consultants, or retained in the S.H.M.O. grade at 80 per cent. of the senior consultant salary. The S.H.M.O. grade would thus be limited to its original purpose and would eventually die out.

The Senior Registrar Grade

84. Those senior registrars at present doing consultant work should be regarded as junior consultants. The remainder who have completed one year of training and have received a favourable report should be given security of tenure and placed on a salary scale which rises by annual increments to the starting point of salary for junior consultants. No absolute guarantee of a consultant post should be given but it should be considered usual for senior registrars to obtain consultant posts eventually. They would be expected to compete freely for consultant vacancies as they occurred, and every senior registrar who had completed two years of service would be regarded as eligible to apply. Should a senior registrar complete ten years without securing a consultant post, however, the Ministry should review the position and determine the area which could best employ an additional consultant.

General Practitioners in the Hospital Service

85. The Union has a particular interest in the place of the G.P. in the hospital because the majority of its members are general practitioners. There are a number of district hospitals with general practitioners on the staff where the G.P.s treat their own patients in hospital. The Union favours an increase of general practitioner beds whenever possible. Their present number is 6,857 (excluding midwifery) out of nearly half a million hospital beds. They are nearly all situated in the country districts.

86. The Union believes, too, that certain general practitioners can play an important role within the hospital service acting as clinical assistants to particular consultants for varying periods. Clearly such appointments would normally have to be limited owing to lack of time available and they would be mainly concerned with specialised duties. These G.P. appointments would necessitate some prior specialist training in hospital usually as a registrar.

Consultation should take place between Regional Hospital Boards and Local Executive Councils as to the best method of bringing general practitioners into the hospital field. Existing partnerships or established single-handed practitioners should be encouraged to take on new partners with the experience necessary to undertake clinical assistantships in the local hospitals. Executive Councils would take such experience into account when appointing doctors to fill practice vacancies.

87. The Union believes that such a policy would benefit the whole medical service by encouraging part-time specialisation of the G.P.; by widening the knowledge of the G.P. team as a whole; by creating the incentive for young doctors to stay in hospital longer; by creating a closer personal contact between the hospital specialists and the general practitioners of each hospital area. Doctors are now forced to enter general practice at an early age because they cannot afford to remain on the junior hospital staff. The lack of longer hospital training for the young G.P. is detrimental to the development of general practice itself, in that it creates a large body of general practitioners with a restricted experience of hospital work and specialist practice.

Proposals for an Intermediate Career Grade

88. The Central Consultants and Specialists Committee of the British Medical Association put forward views on the future of hospital staffing in April, 1955, in a report issued by the Medical Staffing Sub-Committee (the Strachan Committee). This was set up in 1954, and its recommendations with minor modifications were then accepted by the Joint Consultants Committee. However, following discussions in Medical Whitley Council "B" the Joint Consultants Committee modified its views and concluded that "any revision of the structure of hospital medical staffing must be preceded by a complete review of staff in all areas, in order to determine the volume of work requiring consultants for its proper performance and the need for any changes in junior staff." The M.P.U. agrees that a complete review of hospital medical staffing is urgently necessary. Until this has been done no permanent solutions to the problems of staffing can be found. It would not, however, be appropriate to delay any longer a revision of existing arrangements. The Union believes that its proposals for an enlarged consultant grade

would meet the main existing difficulties, without prejudice to any further modifications which may be shown to be necessary when more information is available.

89. *The Lancet*, in an editorial of June 1st, 1957, put forward the opinion that a second permanent grade of senior medical staff was necessary in the hospital service. There is no doubt that this view has some support but in the present state of opinion it is certain that a decision along these lines would not only be unwelcome but give rise to fears for the future status of consultants. The Union believes that some form of compromise on this issue will be necessary, and hopes that the Royal Commission will view favourably the suggestions already outlined above.

90. In view of the critical state of hospital staffing it is perhaps surprising that no agreement has so far been reached. It is worth examining the attitude of various interested groups to these proposals to see whether there is any substance in the objections raised which have prevented agreement. Proposals of this character are seldom examined solely on their general merits for they would ultimately affect the remuneration and prospects of many thousands of individual doctors, and are judged in part by the effect they would have on the career of the doctor concerned. The Union, in putting forward its views above, has had constantly in mind the state of medical opinion at each level of the service. Nevertheless it is possible to find common ground between the many comments which have been made.

The Views of the Various Interested Parties on the Creation of an Intermediate Consultant Grade

The Registrar's Viewpoint

91. The attitude of the registrars has varied a great deal from time to time, but since the reduction of senior registrar posts to an agreed figure, many registrars have given up the hope of reaching senior registrar status and thus going on to become consultants. Some have left the hospital service for public health and general practice or have emigrated; those who remain tend to favour the formation of a sub-consultant grade within the hospital service because they see the possibility of a permanent career with security for themselves in this grade.

The Senior Registrar's Viewpoint

92. The senior registrars have already reached a high standard of work and are feeling their feet as they prepare to step up to consultant status. Some may well consider that in the present circumstances they would prefer any permanent post in any available grade, but there is no doubt that the majority of the 1,200 senior registrars favour the view that all should step into the consultant grade. Any attempt to retain the present S.H.M.O. grade or to introduce a new sub-consultant grade would be resisted.

The S.H.M.O.'s Viewpoint

93. The Union estimates that about 2,000 S.H.M.O.s are actually carrying out consultant duties with purely nominal supervision. Nine hundred and sixty have already applied to be regarded as consultants and their cases are at present being re-examined. Within this grade, therefore, is to be found the strongest possible opposition to a new permanent sub-consultant grade. A few years ago many might have settled for such a grade with a higher status and salary than the present S.H.M.O.; but continual delays have caused opinion to harden against such a solution. The sense of injustice is very great and only a complete review can re-establish confidence.

The Consultant's Viewpoint

94. The views of members of the consultant grade are hard to determine. The grade is a large one with over 7,000 members. Many are young consultants, proud to have achieved a position of responsibility and greatly absorbed in their work which presses upon them from all sides. Faced with the problems of so many patients they have little time to see the Service as a whole or to concern themselves with hospital staffing problems or medical

remuneration. The machinery which was set up by the British Medical Association to represent them and is criticised elsewhere in this memorandum is not made use of. The general view seems to be that matters had better be left to those who have the time and interest to deal with such affairs. The result is that no one really knows what consultant opinion is on any question of the day. Probably the main body of consultants are prepared to leave matters as they are. Since they have already achieved consultant status and are not personally involved in any difficulty they provide no impetus towards a solution of the problem.

95. As the work of a consultant character is on the whole being efficiently carried out with the help of S.H.M.O.s and senior registrars many consultants do not realise the need for an increase in the establishment. One must add that any substantial increase in the numbers of consultants must under present conditions greatly diminish the rewards which those already established can expect to earn from domiciliary visits and private practice.

Ministry of Health

96. We have now to consider the standpoint of the Ministry of Health. Its accent has been on economy for some years without regard to the merits of the case. The 1954 Award was accepted by the Joint Consultants Committee because the Government would not agree to apply the "betterment" recommended in the Danckwerts Award to hospital doctors.

97. There can be no doubt that in recent years the attitude of the Ministry towards the problems of hospital staffing (influenced, no doubt, by the Exchequer) has been blindly restrictive and therefore damaging to one of the nation's precious assets—skilled medical manpower.

98. The attitude of the Ministry towards the creation of an intermediate sub-consultant grade is not known. The proposals put forward in the Strachan report of the Central Consultants and Specialists Committee and accepted with modifications by the Joint Consultants Committee were withdrawn before discussion with the Ministry could take place. It is clear, however, that under pressure from the Exchequer the Ministry of Health will always favour the creation of more posts paid on a lower salary scale, whatever its designation.

A Compromise Solution

99. The Union has set out the attitude of both the Ministry of Health and the various sections of the hospital staff towards the creation of a new permanent sub-consultant grade. It is our aim to seek a practical solution, satisfactory to all those concerned. There is doubt that the majority of the hospital medical staff stand together for a substantial increase of consultants (perhaps as many as 2,000) while the Ministry fear to face the expense.

100. In putting forward our proposals for an extension downwards of the consultant grade by the addition of junior consultants beginning on 80 per cent. of the consultant scale the Union seeks to introduce an equitable solution which, it is believed, would be acceptable to the majority of the profession.

NEGOTIATING MACHINERY

101. There are approximately 20,000 doctors employed in the hospital service and all negotiations on their behalf are conducted by the Joint Consultants Committee, which is also the staff side of the Whitley "B" Committee, of the Medical Whitley Council. The constitution of the Joint Consultants Committee is therefore of great importance. It consists of 17 medical members of whom 11 are appointed by the Royal Colleges and Scottish Corporations and six by the Central Consultants and Specialists Committee of the British Medical Association. There are two dental members. Thus the representatives of the Royal Colleges (which are academic and examining bodies) form a permanent majority. Of the present members all are either part-time consultants or whole-time professors or readers of medicine attached to universities. Eleven members of the Committee also serve on Regional Hospital Boards or on the boards of governors of teaching

hospitals and thus have responsibility for the economic administration of the hospital service.

102. The Central Consultants and Specialists Committee of the B.M.A. is an autonomous committee, i.e., its decisions are not subject to ratification by the Council of the B.M.A. although they must be reported to it. Its constitution is as follows:—ten members, engaged exclusively or predominantly in consultant practice, appointed by B.M.A. machinery; thirty-two members (two from each hospital region) elected from Regional Consultants and Specialists Committees; ten members appointed by corresponding committees in Scotland; five members appointed by other B.M.A. committees; two members by the S.H.M.O.s' group of the B.M.A.; two members of the Junior Medical Staff group of the B.M.A. and one member by the committee of the other special groups of members. The Central Consultants and Specialists Committee has power to co-opt up to three additional members.

103. The majority of the Committee is therefore selected on a regional basis and can be said to represent all the senior hospital medical staff in the regions. The Consultants and Specialists Committee normally meets every two months.

Is the Present Negotiating Body Properly Constituted?

104. Comparing the constitution of the two main committees of hospital medical staff it is surprising that the one chosen to conduct negotiations should be the less representative of the two. Those who support the claims of the Joint Consultants Committee would probably make the following points:—

- (1) The Royal Colleges can be said to represent the best traditions of British medicine, and it is reasonable, therefore, to give them a dominant voice in negotiations which determine staffing structure or remuneration.
- (2) Since the consultant grade is the only one carrying full responsibility for the care of the hospital patient it is reasonable that consultants alone should determine staffing arrangements.

Against these views should be set the following considerations:—

105. The Joint Consultants Committee, as constituted, cannot be said to represent directly any class of hospital doctor other than part-time consultants. Whole-time consultants (2,400), S.H.M.O.s (2,610), senior registrars (1,176), J.H.M.O.s (806), registrars (2,822) and other junior hospital staff (5,449) are not directly represented on the negotiating machinery.

106. The membership of the Joint Consultants Committee is almost entirely from the teaching hospitals. Fourteen out of seventeen medical members hold appointments at teaching hospitals. Yet there are only thirty-six teaching hospitals compared with 3,600 hospitals in the regions.

107. Out of seventeen medical members of the Joint Consultants Committee, eleven also hold appointments either as governors of the teaching hospitals or as members of the Regional Hospital Boards. Thus a substantial majority of the staff side of Committee "B" of the Medical Whitley Council have a dual loyalty—to their medical colleagues and to the service administration.

The Central Consultants and Specialists Committee

108. As we have already stated, most of the members of the C.C. and S. Committee are elected by the regional consultants' committees. There is one committee for each hospital region; elections take place each year; all senior hospital medical staff (consultants and S.H.M.O.s) have the right to nominate and elect any of their colleagues to serve on the committees; from each regional committee two delegates are elected annually to serve on the Central Consultants and Specialists Committee.

109. The electoral machinery would thus appear to have been designed to provide for proper representation. Yet it has certain weaknesses.

(a) There does not appear to be any standard democratic machinery for the election of these committees.

(b) the S.H.M.O.s who constitute approximately a quarter of the senior hospital medical staff obtain very inadequate representation on the regional committees. In some regions there is no S.H.M.O. representation and in no instance does the representation reach a quarter of the committee membership. (S.H.M.O.s form 26 per cent. of senior hospital medical staff.)

(c) The junior hospital medical staff are unrepresented on the regional committees except in some instances by co-option.

Representation of S.H.M.O.s and Junior Staff

110. Some years ago the various grades of hospital medical staff who felt that their particular interests were not being properly represented by the existing machinery formed groups to press their claims. The S.H.M.O. group, originally independent, was eventually recognised by the B.M.A. and given two seats on the Consultants and Specialists Committee. The registrars also formed their own group independently and were later brought within the B.M.A. and received similar representation on the Central Committee. Recently their scope has been widened so as to represent the interests of all junior staff. The junior staff's interests are therefore represented by two members of a committee of 62—a committee which itself has a minority representation on the staff side of the Whitley machinery.

The Union's Views on the Present Negotiating Machinery

111. As will be seen from the above description the negotiating machinery for hospital medical staff has grown up piecemeal. Despite certain concessions to particular grades the staff side of Whitley "B" remains unrepresentative of the interests of most hospital doctors. Unlike the general practitioner side of the Service there is no statutory area committee elected to serve the interests of all the doctors in that area from which a central committee can be elected. The Local Medical Committee (160 in all) are elected triennially from all the general practitioners in each area; these committees meet monthly; they elect a number of sub-committees for different purposes; they form joint sub-committees with the Local Executive Councils for certain statutory objects; they are looked to by local practitioners to protect their interests; they elect delegates to an annual conference of all Local Medical Committees at which matters of common interest are discussed. The executive committee of this Conference is the General Medical Services Committee, the body which negotiates on behalf of general practitioners.

112. On the hospital side, the equivalent to the Local Medical Committees does not exist. The only hospital committees in any way comparable are the Hospital Group Medical Advisory Committees whose functions, as the name indicates, are mainly advisory. These committees elect delegates to the Regional Consultants and Specialists Committees which in turn send delegates to the Central Consultants and Specialists Committee. The chain of democratic representation, in so far as it functions effectively and the senior hospital staff is concerned, is complete up to the level of the Central Committee.

113. The junior hospital staff, most of whom are working only temporarily in the hospital service, cannot expect to be represented in a similar manner. Yet their interests should be the continuing concern of the staff committees at all levels. The Union believes that members of the junior staff representing the views of their colleagues (as ascertained through their own regional B.M.A. machinery) should be co-opted on all Hospital Group Medical Advisory Committees and Regional Consultants and Specialists Committees. The junior staff should also have adequate representation both on the Central Consultants and Specialists Committee and on the staff side of Committee "B" of the Whitley Council.

114. There is one aspect of the hospital service which must be noted in connection with any discussion of negotiations. More than half the hospital doctors are entirely dependent on the goodwill of their seniors for their prospects and promotion. To complain of one's hours of work or the extent of responsibility undertaken is feared by many to prejudice one's future career. Whether this fear is justified is irrelevant. It exists and thus prevents the presentation and correction of legitimate grievances.

115. The Union believes that much of the present dissatisfaction with pay, prospects and conditions of service derives from the lack of effective negotiating machinery. The members of the Joint Consultants Committee doubtless do their best to improve the conditions of hospital medical staff. If they fail it is largely due to their remoteness from many of the doctors they claim to represent. The only solution is a complete overhaul of the machinery of negotiation.

116. To enable all hospital medical staff to have an effective voice in the negotiations requires changes in both the regional and central machinery. Since those members of the regional committees who are chosen to represent their colleagues will almost inevitably be consultants some way must be found to represent effectively the interests of other grades in the negotiating machinery.

The Union's Proposals

117. The Union believes that the following modifications should be made in the existing machinery:—

- (1) The Regional Consultants and Specialists Committees should be renamed the Regional Hospital Medical Staff Committees.
- (2) Elections to the Regional Consultants Committees should be conducted according to specified procedures including prior notification of elections, nomination by post followed by a secret postal ballot. Doctors who serve on Regional Hospital Boards or boards of governors should not be encouraged to stand.

Junior Hospital Staff Group

- (3) The Junior Hospital Staff Group of the B.M.A. should develop an effective regional machinery to represent the views of its members (who are not necessarily members of the B.M.A.) regionally and nationally. The hospital group medical advisory committees and the regional consultants and specialists committees should co-opt a number of junior staff to represent the views of their colleagues in the region. If these regional committees are not well informed regarding the problems of the junior medical staff the central committee cannot possibly be. The Junior Hospital Staff Group should have the right to more seats on the central committee.
- (4) The same considerations apply to the S.H.M.O. grade.

Central Consultants and Specialists Committee

- (5) The present composition of the Central Consultants and Specialists Committee should be overhauled so as to ensure that the interests of all grades of doctors in the hospital service should be adequately represented. The S.H.M.O. group (as long as the number in that grade remains substantial) should be more fully represented than it is at present. It is desirable that a proper balance between doctors employed in the teaching hospitals and regional hospitals should be maintained in the membership of the Committee.
- (6) To provide proper representation of all grades and of the regional and teaching hospitals the Central Consultants and Specialists Committee would have to be enlarged. It should have standing sub-committees to deal with problems of the various grades. The majority of the members of the Central Consultants and Specialists Committee would continue to be elected and would represent hospital medical staff irrespective of their membership of any particular organisation. All interested professional organisations should also have the opportunity of having their views heard on this committee.

Joint Consultants Committee

- (7) To make the chain of democratic representation complete the Central Consultants and Specialists Committee should be fused with the Joint Consultants Committee so as to maintain a majority of elected members. The Royal Colleges and Scottish Corporations, the British Medical Association and the Medical Practitioners' Union would all be able to

present their particular view-points on this Committee. Yet the final policy decisions would rest with the majority of elected representatives.

- (8) The enlarged Central Consultants and Specialists Committee (which would be better named the Central Hospital Medical Staff Committee) should have permanent autonomous powers granted to it by the B.M.A. Council. If these powers were revoked it should become an independent committee.

Staff Side of Whitley "B" Committee

- (9) The staff side of Committee "B" of the Medical Whitley Council should be elected from the new central committee. Junior hospital staff and S.H.M.O.s should have representation.
- (10) The Union believes it undesirable that a preponderance of the members of the staff side of the Whitley "B" Committee should also be members of Regional Hospital Boards or governors of teaching hospitals.

Management Side of Whitley "B" Committee

- (11) The constitution of the management side of the Whitley "B" Committee was changed following recommendations of the Guillebaud Committee so as to give the employing bodies greater representation. This structure should be maintained.

Whitley Machinery

- (12) The Whitley machinery would continue to function as at present. In the event of a dispute with the management side reference would continue to be made to the Industrial Court. Medical organisations which are not trade unions cannot take advantage of the No. 1376 Industrial Disputes Order (1951) which enables employees to refer a dispute to arbitration without the consent of the employer. If the Medical Practitioners' Union were to take part in the negotiations on behalf of hospital medical staff it could invoke the Industrial Disputes Order in the event of a dispute.
- (13) The operations of the Whitley machinery need not preclude the establishment of some other mechanism for reviewing the remuneration of all medical men and women working in the N.H.S. at regular intervals. The Union will offer evidence on a general method of review in a later memorandum.

SUMMARY

1. The changing structure of medicine requires a reassessment of the hospital staff position.

Teaching Hospitals and Regional Hospitals

2. The teaching hospitals and the regional hospitals each present special problems. It is felt that the teaching hospitals occupy too dominant a position in the hospital service. Avenues of promotion lie almost solely through teaching hospitals.

Hospital Establishments

3. Consideration of remuneration of hospital medical staff must take into account the responsibilities of different grades. There is evidence that the establishments of hospitals vary widely. The Union asks for a complete review of hospital establishments.

4. There is evidence that junior hospital medical staff are undertaking duties and responsibilities for which they are not trained or remunerated. Much consultant work is being undertaken by S.H.M.O.s and senior registrars. This should cease.

5. It is clear that the number of consultants in the hospital service is insufficient. The Union recommends a large increase in the number of hospital consultants following a review of establishments.

Divorce of General Practice from the Hospital Service

6. There is an ever-widening gulf between the hospital service and general practice. The Union believes this is against the best interests of medicine and of the patient.

Pay and Prospects of Hospital Medical Staff

7. The inevitable inconveniences associated with short-term appointments of junior hospital medical staff should be recognised in the level of remuneration paid.

8. The prospects for young men and women entering the hospital service are exceedingly uncertain. At the present time they have frequently to wait until the age of 35 or 40 before obtaining security of tenure. This is against the best interests of the service. Many fully-trained specialists have to leave the hospital service and either to emigrate or to seek an entry into some other field of medicine.

The Present Position

9. The difficulties of each hospital medical grade are examined.

The Future Staffing of Hospitals

10. The Union asks for a planned policy for hospital staffing and lists the criteria to be applied.

Junior Staff

11. An increase in the remuneration of junior hospital medical staff is strongly recommended not only on the grounds of equity but to meet the need of encouraging young doctors to stay longer in the hospital service.

The J.H.M.O. Grade

12. It is recommended that this grade should be retained for certain limited purposes and better remunerated than it is at present.

The Training of Registrars

13. It is recommended that the training of registrars should take place in certain designated departments of hospitals and that registrars should not be employed generally in the hospital service. The work of the non-designated departments would be undertaken by consultants and house officers.

Senior Hospital Medical Staff

14. It is recommended that a doctor who has held a post of senior registrar for one year should be given security of tenure in the hospital service and that he should receive a rising scale of remuneration which would reach nearly the level at which a junior consultant starts.

S.H.M.O.s

15. The appointments of S.H.M.O.s should be reviewed in relation to the work done. They should either be regraded as senior or junior consultants or retained in the S.H.M.O. grade at 80 per cent. of the senior consultant's salary. The S.H.M.O. grade should gradually die out.

Consultants

16. It is proposed that there should be two consultant posts (a junior and a senior) in one consultant grade; that the present 9-point salary scale should be replaced by one of 14 points; that the junior consultant should start on point 1 (say at 80 per cent. of the present minimum salary) and proceed by 8 annual increments to point 9 and then by 5 triennial increases to point 14.

The senior consultant would start at point 6 and proceed by 8 annual increments to point 14.

17. Various proposals for the creation of an intermediate career grade are examined and the attitude of doctors in different grades towards such proposals set out. The Union believes that its proposals for a widened consultant grade would meet most of the objections raised to an intermediate consultant grade.

Distinction Awards

18. It is recommended that distinction awards should be retained; that approximately $\frac{1}{3}$ of the money available should be allocated to posts rather than individuals; that the remaining $\frac{2}{3}$ should be granted to individuals by a committee which would invite nominations from a number of informed bodies. The awards should be publicly given.

General Practice and the Hospital Service

19. It is recommended that the general practitioner should play an increasingly important role in the hospital service; that the work at present undertaken in many instances by registrars and house officers should be done by G.P. clinical assistants; that Local Executive Councils and Hospital Management Committees should concert their efforts to introduce general practitioners to the hospital service.

Negotiating Machinery

20. It is recommended that the staff side of the negotiating machinery should be radically overhauled so that doctors of all grades feel they are adequately represented. Efficient democratic regional machinery should be set up to represent all grades. The Central Consultants and Specialists Committee of the British Medical Association should be fused with the Joint Consultants Committee to form a new Central Hospital Medical Staffs Committee.

This new committee should contain adequate representation of all grades and include amongst its membership representatives of the Royal Colleges, Scottish Corporations and other interested organisations. The Staff Side of the Whitley "B" Committee should be chosen from the new central committee.

APPENDIX A CONSULTANT STAFFING COMPARISONS

Name of Hospital	Gen. Med. Beds	Consultants Whole-time	Consultants Part-time	Equivalent to Whole-time Consultants	Beds per Consultant Session
Whittington Hospital ..	365	2	3 (9)	4.5	7.4
Barnet General Hospital...	104		2 (7)		
			1 (3)	1.8	5.5
Hillingdon Hospital ...	120	2	1 (9)	2.9	3.9
Ashford Hospital...	120	2	1 (9)	2.9	3.9
Central Middlesex Hospital	193	2	4 (9)	5.5	3.4
West Middlesex Hospital	204	4	1 (9)	4.9	3.8
Bedford General Hospital	96	1	1 (9)	1.9	4.8
Edgeware General Hospital	218	3	1 (4)	3.4	5.9
Northampton General and District H.M.C. (2 hospitals run together, 6 hospitals geriatric beds)	116		2 (9)	1.7	6.4
Kettering and District H.M.C. (2 hospitals run together) ...	42		1 (9)	.9	4.7
New Cross Hospital, Wolverhampton ...	75	1		1.0	6.8
Walsall Hospital ...	130		1 (9)		
			1 (3)	1.1	10.8

Notes:

(1) The figures in the table may have changed since they were obtained.

(2) The Union has prepared this table solely to illustrate the variability of consultant staffing. Accurate comparisons between individual hospitals could be made only after a detailed study of all the factors concerned.

APPENDIX B

	Hospital In-patient Beds Gt. Brit. (1955)	Consultants and S.H.M.O.s June, 1955	Sessions per person	Consultants June, 1955	S.H.M.O.s June, 1955	Beds per Consultant
General Surgery ...	38,729	1,202	7.6	988	214	39
General Medicine (including chronic sick) ...	96,726	1,154	7.1	932	222	104
Diseases of the Chest ...	35,772	776	10.3	346	430	103
Mental Health ...	239,526	1,042	9.4	633	409	379

The table above gives a statistical review of the position as regards senior medical staff in relation to hospital beds in Great Britain for four important specialties. These figures are for 1955. The numbers of medical staff were published in the *British Medical Journal* of June 30, 1956, and relate to the month of June, 1955. The numbers of beds are those available during 1955 and are taken from the *Hospitals' Year Book* of 1957, published by the Institute of Hospital Administrators.

Similar calculations could be made for other specialties. It might be difficult to draw valid conclusions without making a special survey of arrangements in many parts of the country. If such investigations were done it should be relatively easy to relate the numbers of consultants required in each specialty to units of population and to numbers of hospital beds.

As regards diseases of the chest, a memorandum has been prepared by the Chest Services Sub-Committee of the Central Consultants and Specialists Committee of the B.M.A. and published in the *British Medical Journal* of April 13, 1957. This memorandum draws attention to the increasing duties falling on the chest services of the country which have more than offset the decline in the need for beds for the treatment of pulmonary tuberculosis. It recommends that there should be one consultant physician and one assistant physician in this specialty for every 100,000 of the population. Assistant physicians are usually in the S.H.M.O. grade, but it is recommended that the consultant/S.H.M.O. ratio should always be greater than one. At the present time there are fewer chest consultants than S.H.M.O.s with a consultant/S.H.M.O. ratio of only 0.8. It is considered that the balance should be restored as compared with other specialties by increasing the number of consultant posts by 40 per cent. to about 500, without increasing the number of S.H.M.O.s. It can be said therefore that there is a shortage of chest consultants amounting to about 150.

It is also considered that each consultant should have between 50 and 60 beds. At 50 beds per 100,000 of population the total number of beds required would be about 25,000 for Great Britain or about 10,000 less than those available in 1955. The hospital facilities are thus more than adequate for present needs, but they cannot be efficiently used because of medical staffing deficiencies. Chest consultants are sometimes responsible for between 150 and 200 beds in addition to undertaking other duties such as out-patient clinics, research, committee work, etc. They carry on only by employing excessive numbers of subordinate medical staff who undertake the day-to-day duties and attend to in-patients with only minimal supervision. There is a real need for more chest consultants. Similar assessments for other specialties should be made in order to estimate more precisely the extent of present needs.

**THE THIRD MEMORANDUM OF EVIDENCE ON THE REMUNERATION OF
HOSPITAL MEDICAL STAFF AND GENERAL PRACTITIONERS IN THE
NATIONAL HEALTH SERVICE**

1. When the Union presented its evidence to the Royal Commission in August, 1957, and April, 1958, it stated that it would present a third memorandum of evidence in which it would deal with the amount of remuneration which the Union believes should be received by medical men and women employed in the National Health Service, with the desirable spread of incomes, and with the relationship between the remuneration of doctors working in hospitals and of general practitioners.

It was hoped that the result of the statistical enquiry conducted by the Royal Commission would be available before this third memorandum was prepared. Indeed, in paragraph 11 of our first memorandum it was stated that, without this information, "the bodies giving evidence and the Royal Commission itself will be without the data on which any firm proposals could be based". It is clear, however, that these figures will not be available for some time to come. The Union considers that it should, without further delay, offer the Royal Commission the results of its deliberations on the level of remuneration in both the hospital and general practitioner branches of the National Health Service.

2. The Union is also handicapped in not having available the results of the Commission's enquiries into the level of remuneration of other comparable professions. No private organisation is in a position to collect evidence of this type. The Union must therefore base its recommendations on the changes in the cost of living index that have taken place since the time of the Danckwerts Award. As each month passes small changes in the Government cost of living index occur and there may well be further changes before the Royal Commission is in a position to present its report. The present position would appear to be that there has been a 30 per cent. increase in the cost of living since 1953. The recommendations which follow are based on this figure.

3. Members of the Union are acutely aware of the length of time which elapsed between the first application by the profession for an increase and the establishment of the Royal Commission. A further two and a half years will certainly have passed before the Royal Commission publishes its report. The Union believes that any recommendations made by the Commission to increase remuneration should be retrospective, at least to the date of the Commission's appointment. The rate of betterment recommended should therefore vary between 24 per cent. and 30 per cent. according to the period to which it refers.

4. The Union, however, does not wish to confine its evidence to a recommendation of a percentage increase to the levels of remuneration prior to the first interim award. In previous memoranda of evidence it has been made clear that in many respects the present method of distribution does not conform to what the Union thinks is desirable. The Union proposes, therefore, in this final memorandum, to recommend levels of remuneration for hospital doctors and general practitioners, keeping in mind not only the question of global betterment but the special requirements of particular groups.

5. In making its recommendations the Union has kept in mind certain points of principle which it considers fundamental to any consideration of the question of remuneration. They are as follows:—

- (1) It is important to develop a pay structure which will encourage the best service to patients in the N.H.S. and enable doctors to employ fully their medical skill with satisfaction.
- (2) The level of remuneration is not the sole consideration. Both hospital doctors and general practitioners need to see their way ahead to useful and settled careers in medicine. They must therefore be assured of security of tenure and of reasonable prospects of promotion.
- (3) It is impossible to settle the level of remuneration of one branch of the Service in isolation. We are particularly concerned in this memorandum with a proper relationship between the remuneration of hospital doctors and that of general practitioners, and in making subsequent recom-

mentations due regard has been given to this relationship. We want young men and women to be attracted into the branch of medicine which needs them most and to which their individual aptitudes make them most suitable.

HOSPITAL MEDICAL STAFF

6. The Union has already made it clear that it believes that a review of medical establishments in the hospital service is urgently needed. Such evidence as we have seen suggests that many hospitals are understaffed and that junior medical staff are called upon to undertake a degree of responsibility far exceeding that which might reasonably be expected. We believe that such a review would show not only that there is an overall shortage of consultants in the Service but that certain regions are understaffed as compared with others.

7. Apart from the overall shortage of consultants there is a great lack of junior medical staffs in many regions. Some hospitals find it almost impossible to fill vacancies of junior positions. It is certain that a large number of young men and women on completion of their compulsory pre-registration work decide not to waste time working in hospitals where their remuneration is low and the prospects of promotion poor, but to go straight into general practice where they hope in a few years' time to become established principals. It is in the public interest that this trend should be reversed. If the young doctor could be persuaded to spend an additional two years working in the hospitals it would go far to solve the junior staffing problem of regional hospitals and would also ensure that the doctors entering general practice subsequently had a higher level of training. There is, therefore, a strong *prima facie* case for paying junior hospital staff at a higher level of remuneration.

8. Not only must the young doctor be encouraged to stay in hospital for a longer time, but those who decide to make a career in the hospital service should have security of tenure and reasonable prospects of promotion once they have been selected as suitable. At the present time the most junior post which enjoys security of tenure is the senior hospital medical officer. This means that out of 20,285 doctors in the hospital service 10,253 are on short period terminable posts.

The Union believes that a senior registrar, once he has held the post for two years and is found suitable, should be able to settle down to a permanent career in the hospital service.

9. We set out below the actual levels of remuneration which are recommended for each grade of the hospital service. Comment on these suggestions follows later.

House Officers:

(Pre-registration) ... £850 (The differential between the two grades would be abolished.)

(Fully registered) ... £1,000 (Provision should also be made for the payment of an inducement element where considered necessary to attract applicants.)

Senior House Officers ... £1,200

Junior Hospital Medical Officers... ... £1,250 × £60 (10) = £1,850

Registrars £1,400 1st year
£1,500 2nd year

Senior Registrars ... £1,650 × £147 10s. (4) = £2,240
£2,240 × £60 (16) = £3,200 i.e. the top point of the S.H.M.O. scale. On promotion to Consultant the Senior Registrar would enter at the point above that he had reached on the S.H.M.O. scale.

S.H.M.O.s £2,240 × £60 (16) = £3,200

Junior Consultants ... Pt. 1 to Pt. 9 = £2,240 × £126 5s. = £3,250, thence up the Senior Consultant scale by triennial increments of £150 to maximum of £4,000.

Consultants (without distinction awards) ... £2,800 to £150 - £4,000

R.H.B. administrative medical staff:—

S.A.M.O.	...	...	as for Consultant with 'B' award
Deputy S.A.M.O.	...	...	as for Consultant with 'C' award
S.M.O.	...	...	as for Consultant
R.M.O.	...	...	as for Consultant

Comment on Recommended Scales of Remuneration

10. (a) House Officer Provisionally Registered

The Royal Commission will note that the Union recommends a very substantial increase of remuneration for these officers. Indeed this works out at nearly 100 per cent. betterment on their salaries prior to the interim awards. We have taken into consideration that these posts are held after six years' training ending with the acquisition of a degree and that the house officers are often required to undertake responsible work. £850 per annum appears to the Union the minimum they should earn.

(b) House Officer Fully Registered

These officers are fully qualified and often take considerable responsibility. A salary of £1,000 is fully justified. It would, in fact, be comparable with that of an assistant in general practice. Thus there would be no immediate incentive to leave the hospital service. The additional hospital experience gained would still be valuable if, at a later date, a decision were made to go into general practice.

(c) Senior House Officer

This grade is of great importance to the hospital service, for many rural hospitals depend on the senior house officer for the day-to-day care of patients. The number of hours on duty and on call are often excessive, particularly in the case of a provincial hospital or where the number of resident medical staff is low. The Union believes that a senior house officer should earn a minimum salary of £1,200 per annum. This salary would encourage young men and women to spend an additional year in hospital service, and would not only help the problem of hospital staffing, but would raise the standards of medicine for those who finally elect to enter general practice.

(d) Junior Hospital Medical Officers

The Union has referred in detail to the considerable difficulties presented by this grade, and submitted that whilst in the main it is a grade which should die out, it may be retained for certain limited purposes.

These purposes are highly specialised and carry a load of responsibility, commensurate, we believe, with the scale we now recommend. While the grade remains it should offer reasonable career prospects.

(e) Registrar

It would be to the great advantage of the Health Service if more young doctors were willing to remain in hospital and thus become more highly trained in one branch of medicine. Although many would eventually leave and enter other fields of medicine, they would take their skills with them. We repeat that unless there is a substantial increase in remuneration, economic considerations will encourage too many doctors to leave the hospital service for general practice. The scale recommended shows a 60 per cent. betterment rate over the 1957 levels.

(f) Senior Registrar

The senior registrar is interested in his level of remuneration, but is even more concerned about the possibilities of advancement. The Union has already suggested once the first 2 years have passed in the post that a senior registrar should be assured of permanent security of tenure in the hospital service. The hospital authorities have had sufficient time, at this stage, to assess the doctor's capabilities. The Royal Commission will be well aware, from other evidence

they have examined, of the very high level of responsibility that rests on the senior registrar.

The pay scale put forward by the Union bears these factors in mind, and after careful consideration, we propose the starting point of £1,650 per annum with four annual increments of £147 10s. which will bring the senior registrar to the starting point of the S.H.M.O. scale. After this, if he has failed to secure a post as either a junior or senior consultant, he would continue to the maximum point of the S.H.M.O. scale.

Should he fail to get an appointment as a consultant it would take twenty years for him to reach his maximum, but the majority of senior registrars would certainly achieve promotion before the end of this period.

(g) Senior Hospital Medical Officer

It is hoped that gradually this grade will be eliminated, and the division of the pay scale for consultants is designed to assist in this process. There will be an interim period, however, and the Union has therefore included a scale to cover that period and those S.H.M.O.s who, by reason of exceptional circumstances, do not go on to the consultant scale.

The special increase recommended we deem to be well justified when the work involved and the responsibility undertaken are compared with those of a consultant.

(h) Consultant grade

The Union proposes an extension in depth of the consultant grade. The senior consultant would normally proceed by eight steps from £2,800 to £4,000 per annum. The junior consultant would be appointed at a lower salary, namely, £2,240 per annum, and would proceed by slower stages (14 in all) to the maximum. There would therefore be considerable advantage in being appointed to the senior post, but even if junior consultants fail to obtain such a post they would know they would in the long run reach the maximum point in the scale. The Union has reason to believe that this solution of the consultant staffing problem would be acceptable to the profession.

Whole-time Consultants

11. In previous evidence the Union has already stated its views on the relative advantages of whole-time and part-time consultants. The Royal Commission will, no doubt, have reviewed the serious anomalies which exist at the present time.

The one reform, however, which the Union wishes to press at this stage, is that all consultants should be employed on a sessional basis, and that those who are at present graded as whole-time consultants should be considered as being employed on a sessional basis of 11/11ths.

Distinction Awards

12. The Union believes that the amount of the distinction award should be increased. There has been no increase since 1948 when the awards were first applied and it is recommended that a 60 per cent. betterment be added to the existing figures.

As has already been stated in our previous memorandum, we believe that the majority of the awards should be attached to posts rather than to individuals and that the minority of awards which are assigned to individuals for outstanding work performed should be given publicly.

Senior Administrative Medical Officers

13. The Union believes that the administrative medical staff of the Regional Hospital Boards have not received a proper recognition for the high responsibility they have to take. It is recommended therefore that senior administrative medical officers should receive the equivalent of a consultant's salary with a 'B' merit award; that his deputy should receive the equivalent of a consultant's salary with a 'C' merit award and that the other medical staff should be paid on the consultant scale.

Regional Psychiatrists

14. The Union recommends that the regional psychiatrists employed by the Hospital Boards should be paid on the same scale as that applicable to other clinical consultants in the Service.

Emoluments in Kind

15. The Union is aware that graded charges made for board and lodgings can be used to increase or decrease the real worth of remuneration. A doctor should receive adequate pay which has no need to be buttressed by emoluments in kind. We therefore recommend that charges for board and lodging for all resident junior medical staff should be made at a single standard rate. The exception to this rule would be where accommodation of greater luxury than usual was provided and where the additional charge could be seen to be clearly justified. A "ceiling" to these higher charges should be imposed.

Lecture Fees

16. Under the present system there are considerable differences in the rates paid to doctors of various grades when they deliver lectures. The Union can see no justification for this. All lecturers are fully qualified in the subject on which they lecture, and the time and effort involved in preparation and delivery is the same, irrespective of the grade of lecturer.

We recommend, therefore, that all lectures should be paid for at the same standard rate.

Clinical Assistantships

17. Clinical assistantships fall into two distinct categories: those which are primarily of a training nature and which enable a doctor to extend his medical experience, and those in which clinical responsibilities are undertaken. The Union would like to see a clear demarcation between these two categories and recommends that the latter should be paid at sessional rates in conformity with the scales operating for other hospital doctors doing similar work. The present rates of pay for 10b appointments are grossly inadequate.

GENERAL PRACTITIONER REMUNERATION

18. The Union had hoped before offering its third memorandum of evidence to have available figures which would show the present distribution of income among general practitioners. Since these figures are not available it will be necessary to confine the statements in this memorandum to general principles.

19. In its first memorandum the Union recommended that the Royal Commission should examine the possibility of basing the future remuneration of general practitioners on "the appropriate reward for a practitioner solely engaged in the care of N.H.S. patients" (para. 43). The view was expressed that an urban practitioner who had on his list some 2,200 patients should earn from capitation payments and loadings enough to give him a good standard of living irrespective of any other work undertaken. No doctor should be under economic pressure to take on a large list or seek additional medical work in order to earn a decent livelihood. The acceptance of this recommendation would entail, of necessity, a rather different system of payment. If the present global central pool system were retained, and a flat rate percentage increase applied, it would mean that the single-handed urban practitioner with an average-sized list could not possibly receive the income to which the Union feels he is entitled.

20. The Union also expressed the view that the payment of net remuneration should be divorced from the repayment of expenses (para. 48). This is an exceedingly complex question to which the Union does not feel that it has a complete answer. Nevertheless, after a careful reconsideration of all the difficulties involved, the Union is sure that the recommendation is a sound one. It is hoped that the Royal Commission, with all the facts and expert advice at its disposal, will recommend, at least, that a system of distribution should be worked out by which a general practitioner's expenses are repaid on a realistic basis. Beyond this, the Union would welcome positive proposals which would indicate methods by which this could be done.

On three separate occasions the Union has put forward schemes, each of which would have this result. None of these schemes has been free from criticism, and perhaps each has tried to recommend too much in the first instance. It may be possible to devise a scheme which would go a long way to achieve this end without requiring the repayment of the actual expenditure incurred by each practitioner. One example of such a scheme would be to group practitioners according to their average expense ratios and to give each group its appropriate expense ratio. The Union recognises that this does not completely fulfil the original principle put forward, but does go half-way towards that fulfilment.

The Union recommends that even if the Royal Commission decides that it cannot make specific recommendations for the payment of expenses on a more equitable basis, it should advise that a working party should be set up to devise some practical system, based on the principles put forward by the Union.

21. The Union wishes to re-affirm that the maximum permitted list for a single-handed practitioner should be reduced by stages from 3,500 to 3,000 (para. 45). Where an assistant is employed, the principal should be allowed to add a further 1,500 patients to his list for a maximum period of two years.

22. The Union recommended that a capital expenditure loans fund should be established, open to use by all practitioners. It would now go further, and recommend to the Royal Commission that the Government should set aside a substantial sum of money each year to finance improvements in practice accommodation. The Union suggests that a sum of money, about £1,000,000 per annum, should be provided by the Government for this purpose. In deciding on allocations, preference should be given to those groups of practitioners who are willing to work together in group practices.

In addition to giving interest-free loans, the trustees of the fund should be enabled to invest money in building premises for group practices which would remain the property of the Trust Fund and be let to the occupiers at an economic rent.

In some instances existing accommodation could be readily adapted to make it suitable for group practice. In others it would be necessary to erect new buildings. The Union would like to see a more positive encouragement of the improvement of practice facilities in addition to the provision of finance. It is recommended that an advisory bureau should operate under the Trustees. This should include an architectural section which could offer plans for a number of differing types of premises suitable to differing requirements.

23. The Union recommended that the Royal Commission should examine the merit of special loading for doctors with experience (para. 53). It was recommended that a special loading be applied to practitioners between the ages of 45 and 60, but in view of the fact that the age of the practitioner does not necessarily indicate the number of years in practice, the Union would now suggest that the loading should be applied to all doctors with between 20 and 35 years' experience in general practice. In accordance with the general principles being outlined in this memorandum, it is suggested that this loading should be confined to the first 2,000 patients on a practitioner's list. The Union recommends that enough money should be set aside to apply these loadings on a scale which would yield from £100 to £500 to a doctor with 2,000 patients, and that the scale should advance according to the years of experience. For example, a simple scheme would be to give a capitation loading of 1s. per patient after 20 years' experience, with increments of an additional 1s. per patient to be added every three years.

The Union is well aware of the problem that arises with regard to preserving fairness when this loading for experience is given to a doctor who is in partnership. The law of contract makes it impossible to stipulate that this additional income should be retained by the partner earning it. A further consideration is that a partner with an experience loading may have a small list actually, but have a full "notional" list for loading purposes.

The Union recommends that if an experience loading is awarded, the Royal Commission should take this factor into consideration when considering the criteria by which partnership agreements are to be judged (see the following paragraph). In particular, the Commission should consider the share to be given to junior partners and the number of years before parity is achieved.

24. No system of distribution, however carefully it is calculated, can achieve its own purposes unless it takes account of the fact that two-thirds of all practitioners are in partnership (para. 54). The Union has already pointed out that partnership agreements can redistribute money without the knowledge of the Ministry or the General Medical Services Committee. The Union has experience of partnership agreements which deviate widely from the criteria recommended by the Medical Practices Committee. This means in effect that a number of practitioners are offending against Section 35 of the National Health Service Act.

The Union recommended that partnership agreements should have to conform to criteria laid down centrally (para. 54). It is now recommended that these criteria should be laid down by the Medical Practices Committee, and that the Local Executive Council should be responsible for checking that these criteria have, in fact, been met before a partnership is recognised for loading purposes.

25. It is regretted that, for the reason given in paragraphs 1 and 2, the Union is unable to put forward specific recommendations as to the actual levels of remuneration which it feels should be received by practitioners divided into groups based on the size of lists. The Union has already stated in paragraphs 2 and 3 that the percentage increase for all practitioners taken as a body should be equivalent to one which would allow for the changes in the value of money since the Danckwerts Award was given.

26. How this increase should be distributed must clearly be a matter of negotiation between the profession and the Ministry. Indeed, the recommendations made by the Union must of necessity require the appointment of a working party to apply the principles outlined and to devise a method of distribution. The four main principles which the Union has recommended should be applied are:

- (a) to give a maximum reward to the middle-list practitioner with no other sources of income;
- (b) to include a special loading for experience;
- (c) to take into consideration the diminution of the maximum permitted size of lists;
- (d) to separate net remuneration from expenses.

The Union accepts the principle of the "Notional" list as applied at the present time to doctors in partnership and any new system of distribution should retain this device, suitably adjusted to fit in with any financial changes.

27. The Union cannot attempt the task which it believes belongs properly to a working party on distribution, but it suggests that a useful starting point might be to decide an amount which should be received by the "average list" urban doctor (2,200 patients) who is single-handed and has no other sources of income. Before the last two interim awards such a practitioner received £2,370 per annum gross or £1,580 per annum net solely in respect of the care of his N.H.S. patients (para. 41). The Union recommends that such a practitioner should receive £2,200 per annum, or an increase on his net earnings of nearly 40 per cent.

28. If the middle-list practitioner is to receive a 40 per cent increase in his net remuneration, then clearly some other practitioners must receive a percentage increase of much less than 30 per cent if that is to be the average. At the top end of the earning scale the reduction in the permitted maximum will relieve the doctor of some of the pressure of work and is therefore a material though not financial gain.

In view of this, the Union recommends that the full-list practitioner of the future, i.e. one with 3,000 patients, should receive an increase in his present earnings of approximately 25 per cent. The practitioner who now has 3,500 patients may find that when his loss of fees on 500 patients is taken into consideration his total net increase would amount only to about 14 per cent. Nevertheless he would still have an increase, while gaining considerably from the fact that he would be responsible for a smaller number of patients.

The Union would expect that the percentage increase would gradually diminish as the list gets smaller. Thus the maximum benefit would accrue to the middle-list practitioner with a gradual falling off at both ends. This effect would probably be best achieved by adding any new money on to the loading range, and it may prove desirable to extend the range in order to achieve the most equitable type of distribution.

29. The Union hopes that the Royal Commission will accept its recommendation to reduce the maximum permitted list to 3,000. If, however, it is not prepared to do so, the Union recommends that no more than 10s. per capita should be paid for any numbers on the list above 3,000.

30. If any new money were applied to a loading range of 500 to 2,000, the Union believes that this would produce the desirable pattern for all practitioners with lists of more than 500. There is, however, the problem of the very small

list practitioner. Until the interim award was applied these practitioners had had no increase since 1948. Although the Union is of the opinion that it would be unwise to encourage doctors to maintain very small lists, yet in fairness to this group of practitioners it believes that some increase should be given.

31. The Union is aware that the percentage increases quoted in previous paragraphs cannot be accurately assessed in terms of the State's commitments, but it is hoped that these recommendations will be sufficiently clear to indicate the Union's approach to distribution. It should also be noted that, in advocating the basis of remuneration scales, a new principle is involved which makes comparison with the old scales, based on a doctor's overall income from all sources, virtually impossible.

References

All references relate to the Preliminary Evidence on the Remuneration of General Practitioners in the National Health Service presented to the Royal Commission in August, 1957, and recorded in the Commission's files as Memo. No. 21.

Hospital Medical Staff Salary Scales

Pre-Career Grades

House Officers, Pre-registration	...	...	...	£850	2 posts of 6 months
House Officer, Fully Registered	...	...	...	£1,000	1 to 2 years
Senior House Officer	...	...	...	£1,200	1 to 3 years

Career Grades

J.H.M.O.	Registrar	Senior Registrar	S.H.M.O.	Junior Consultant	Consultant
£	£	£	£	£	£
(1) 1,250	(1) 1,400				
(2) 1,310	(2) 1,500				
(3) 1,370		(1) 1,650			
(4) 1,430		(2) 1,797			
(5) 1,490		(3) 1,945			
(6) 1,550		(4) 2,092			
(7) 1,610		(5) 2,240	(1) 2,240	(1) 2,240	
(8) 1,670		(6) 2,300	(2) 2,300	(2) 2,366	
(9) 1,730		(7) 2,360	(3) 2,360	(3) 2,492	
(10) 1,790		(8) 2,420	(4) 2,420	(4) 2,618	
(11) 1,850		(9) 2,480	(5) 2,480	(5) 2,745	
		(10) 2,540	(6) 2,540	(6) 2,871	(1) 2,800
		(11) 2,600	(7) 2,600	(7) 2,997	(2) 2,950
		(12) 2,660	(8) 2,660	(8) 3,123	(3) 3,100
		(13) 2,720	(9) 2,720	(9) 3,250	(4) 3,250
		(14) 2,780	(10) 2,780	(10) 3,250	(5) 3,400
		(15) 2,840	(11) 2,840	(11) 3,250	(6) 3,550
		(16) 2,900	(12) 2,900	(12) 3,400	(7) 3,700
		(17) 2,960	(13) 2,960	(13) 3,400	(8) 3,850
		(18) 3,020	(14) 3,020	(14) 3,400	(9) 4,000
		(19) 3,080	(15) 3,080	(15) 3,550	
		(20) 3,140	(16) 3,140	(16) 3,550	
		(21) 3,200	(17) 3,200	(17) 3,550	
				(18) 3,700	
				(19) 3,700	
				(20) 3,700	
				(21) 3,850	
				(22) 3,850	
				(23) 3,850	
				(24) 4,000	

The figures in brackets refer to the year of service in that particular grade.

BRITISH MEDICAL ASSOCIATION

(Days 5-6 and 23)

MEMORANDUM OF EVIDENCE PREPARED BY THE ASSISTANTS AND YOUNG PRACTITIONERS SUBCOMMITTEE OF THE GENERAL MEDICAL SERVICES COMMITTEE

Note: The following is a copy of a letter received by the Commission from the Secretary of the British Medical Association.

"I am writing to let you know that the Council has received a request from the Assistants and Young Practitioners Subcommittee (a Subcommittee of the General Medical Services Committee) to present to the Royal Commission on Doctors' and Dentists' Remuneration, a document representing the views of that Subcommittee. The Council feels that it should accede to this request, but in forwarding the evidence wishes to emphasise its adherence to the evidence it has already presented, and to indicate quite clearly that it does not accept some of the statements made, nor the conclusions drawn from them, nor their relevance to the Terms of Reference of the Royal Commission."

PREAMBLE

1. This memorandum presents the views and problems of a minority in the Association—practitioners entering and establishing themselves in general practice. The majority of these doctors are young and are likely to be affected by the Royal Commission's recommendations for a longer period than their senior colleagues.

2. The evidence has been collected by The Assistants and Young Practitioners Subcommittee of the General Medical Services Committee. This Subcommittee was set up in 1950 within the Association to look after the interests of assistants and unestablished principals. For practical purposes the latter have been defined as those earning from professional sources less than £1,650 gross per annum. The numbers represented are around 5,000 of whom about 1,800 are assistants. The Subcommittee pledged its loyal support in principle to Council in June, 1956 and February, 1957 for actions taken in connection with the remuneration claim.

3. An analysis of doctors in general practice in the National Health Service classified under age and size of list is contained in the Appendix.

4. All doctors under the age of 30 years have already shared in the financial and other hardships of junior hospital staff outlined in the second B.M.A. memorandum of evidence to the Royal Commission. Since 1953 there has been a statutory requirement of two six-month hospital posts to consolidate in practical experience the knowledge necessary to qualify as a doctor. Similar hospital posts have of course been held by a majority of older doctors in general practice. With two years of National Service the age at which doctors become potentially eligible for general practice for the first time is now from about 27 to something over 30.

5. The Subcommittee wishes to record its disagreement with the view that those who enter general practice have fallen off the ladder of success in medicine. Family practice at its best is a vocation in itself. With widening horizons in medicine and more facilities becoming available the general practitioner will be able to do progressively more for each patient, who, in turn, will desire a progressively higher standard of medical care; with the achievement of better housing the important present day need is for better domiciliary medical care.

ASSISTANTSHIP AS AN INTRODUCTION TO GENERAL PRACTICE

6. The Assistants and Young Practitioners Subcommittee considers that an assistantship provides a very helpful introduction to general practice.

7. Successful careers however have been enjoyed by principals whose previous experience was confined to hospital, overseas medical services, medical branches of the armed services or a variety of posts as locum tenens in general practice. The Subcommittee accepts that continuity in the same practice is useful in gaining the knowledge of people, both sick and well, which is essential for success in general practice, but it is doubtful whether so long as one year in one and the same practice is required for gaining this insight.

8. While the Trainee General Practitioner Scheme has been criticised it is recognised that it provides posts for junior members of the profession which might not otherwise exist. Its overall cost in 1957 of £385,058 must be regarded as out of proportion to the cost of Initial Practices Allowances of £46,148.

REMUNERATION OF ASSISTANTS

9. The Subcommittee would emphasise that in all assistantships including those under the Trainee Scheme and those with view to partnership the fundamental relationship is that of employer and employed. Terms and conditions of service being subject to the law of supply and demand, the recent period of financial stringency imposed upon the profession has been reflected in the terms and conditions of service of assistants.

10. The Spens Committee (1946) recommended that (Recommendation 7):— "On completion of resident hospital appointments a recently qualified practitioner should secure an initial net income of not less than £500 per annum as an assistant to a doctor in general practice". The Spens Committee further suggested (para. 14) in reference to a scheme designed partly to improve training of general practitioners, that "while any practitioner should be free to engage an assistant, approximately 10 per cent. of practitioners . . . should be encouraged to do so", that "such a practitioner should receive as part of his remuneration in a publicly organised service a supervision fee of £100 per annum in respect of an assistant who had no previous experience or only one year's previous experience of general practice", and that "such an assistant should receive £500 in his first year and £600 in a second year if any". In the view of the Subcommittee the present trainee general practitioner scheme is clearly based on this paragraph of the Spens Report, with slight modifications, and consequently the net income of trainee general practitioners should be based on this paragraph "with due adjustment to present conditions". There is no second year in the present trainee general practitioner scheme and the Subcommittee therefore considers that the net salary of £600 for an assistant in his second year in general practice suggested in para. 14 of the Spens Report should be interpreted as applicable to all assistants in their second year in general practice, whether they are employed by the same principal as in the first year or not.

11. In order to correspond with the Danckwerts adjudication on the betterment factor to be applied to the Spens recommendation, whereby 100 per cent. was used as the betterment factor in the calculation of the income of principals, assistants' total net incomes from 1950 to 30th April, 1957, should have been:—

<i>Total net income</i>			
		<i>(including Exchequer superannuation)</i>	<i>(less Exchequer superannuation contribution)</i>
1st year	... ..	£1,000 p.a. net	£927 p.a. net
2nd year	... ..	£1,200 p.a. net	£1,113 p.a. net

The net income of principals was increased by the Government by 5 per cent. on the 1950 figure, as an interim measure on 1st May, 1957. Thus assistants' total net incomes should have become:—

1st year	... ..	£1,050 p.a. net	£974 p.a. net
2nd year	... ..	£1,260 p.a. net	£1,168 p.a. net

The Government made a further interim increase in the net income of principals, of 4 per cent. on the 1957 figure, on 1st January, 1959, and assistants' total net income should have become:—

1st year	... ..	£1,092 p.a. net	£1,013 p.a. net
2nd year	... ..	£1,310 p.a. net	£1,215 p.a. net

However, as has been shown in the Preliminary Memorandum of Evidence, paras. 68-73, for the Spens Recommendation to be fulfilled these incomes should have risen steadily since 1950, giving for 1957-58 an increase of 29 per cent., resulting in the following total net income:—

1st year	... ..	£1,290 p.a. net	£1,196 p.a. net
2nd year	... ..	£1,548 p.a. net	£1,435 p.a. net

12. The salary received by trainee general practitioners from the Ministry of Health (£700 from July, 1948 to June, 1955 then £775 until 1st May, 1957, then £850 until 1st January, 1959, and now £885) therefore has always fallen and still falls very far short of the Spens recommendation as interpreted by Danckwerts, with the addition of 5 per cent and the 4 per cent increases. The figures should now be £1,013 per annum net. Fulfilment of the Council's claim for a 29 per cent increase would necessitate a salary of £1,196 per annum net.

13. The salaries of "permanent" assistants of course have to be paid by the principal and are an expense allowed by the Inland Revenue. They therefore depend on the principal's willingness and ability to pay. It is reasonable therefore to apply the Danckwerts betterment factor plus 5 per cent to obtain appropriate incomes for such assistants, i.e. £974 for first year and £1,168 for 2nd year from 1st May, 1957 to 31st December, 1958; with the further 4 per cent increase on 1st January, 1959 appropriate incomes for such assistants are: £1,013 for the 1st year and £1,215 for 2nd year.

14. At 1st July, 1957 there were 509 "permanent" assistants in their first year to whom the figure of £974 net would at that time have been relevant. There were in addition 956 "permanent" assistants who were in their second and subsequent years and who should have been receiving £1,168 net per annum for the second year and in equity, more for subsequent years.

15. Since the Council's further supplementary Memorandum of Evidence was submitted to the Royal Commission, the Assistants and Young Practitioners Subcommittee and the Medical Practices Advisory Bureau have made further enquiries into assistants' salaries (see below and Appendix, Tables 5 and 6). It would seem that salaries in some parts of the country are lower, in some cases considerably lower, than in the London area. Thus:

Area	Average Gross Salary	Average Car Allowance	Average Net Salary
	£	£	£
(a) Figures supplied by M.P.A.B.:			
January to June, 1958:			
(1) London Office...	1,245	150	1,095
(2) Manchester Office ...	1,270	200	1,070
June to December, 1958:			
(3) Scottish Offices—			
Practices in England ...	1,296	200	1,096
Practices in Scotland ...	1,065	200	865
(b) Other figures supplied by the Assistants and Young Practitioners Subcommittee:			
(1) London ...	1,260	?	1,089
(2) South East England ...	1,166	?	—
(3) South West England ...	1,192	200	992
(4) Sheffield ...	1,180	200	980

It should be noted that the figure for Scotland is based on a very small sample of introductions circularised by the Bureau, which were the only ones available in which full details were given by the Principal.

16. The Subcommittee notes that it is frequently not clear whether the cost of petrol and oil used by the assistant for practice purposes is paid for by the assistant, or directly by the principal. In the figures given for London above, it is possible that in many cases the petrol and oil was paid for by the assistant. The Subcommittee wishes to emphasize that the car allowance is intended to cover maintenance and depreciation, and not petrol and oil, which should be paid for separately by the principal in accordance with Association policy (Medical Practitioners Handbook Section V, paragraph (3)).

17. The Subcommittee emphasizes that the figures quoted are averages and apply to assistants with widely differing experience of general practice, from nil

to five or more years. The Subcommittee considers that the Spens recommendation for assistants in their first two years in general practice should be fulfilled in accordance with present day values of money, and that these recommendations should be minimum recommendations applicable to all whole-time assistants. It considers that an assistant with more than two years' experience, should normally receive extra remuneration in accordance with his greater experience. The Subcommittee further considers that these recommendations should be reviewed at three yearly intervals in the light of general trends in remuneration.

18. Emoluments offered to assistants may include living accommodation. This can mean that if the assistant is married, especially with children, he may have to maintain two homes, or else live in accommodation which may be inadequate. The accommodation may be tied to the employment, placing the assistant at a disadvantage in any dispute with his principal, especially when accommodation is scarce. In a number of cases this means living on or above practice premises. Here the assistant's wife (like the principal's) must of necessity often act as message taker and sometimes even as surgery cleaner. For these services there is often no payment although the wife may as a result be tied to the house for long periods and the assistant will not be able to claim tax relief on any sum he may pay his wife for such duties.

19. Notwithstanding all the above the Subcommittee records that there are many happy assistantships of mutual benefit to both parties and expresses its earnest hope that the Royal Commission will recommend that all assistants be awarded salaries in accordance with Spens as interpreted by Danckwerts plus the betterment factor of 29 per cent, and that a financial framework for the profession be produced which will enable such a recommendation to be effective.

CONDITIONS OF WORK OF ASSISTANTS

20. The B.M.A.'s Medical Practices Advisory Bureau recommends certain safeguards in the contract of employment, a copy of which is appended (Assistantships—Medical Practitioners Handbook). The Subcommittee believes that these are often observed, and that indeed in some cases conditions are better than the minimum recommended. It should be realised, however, that the relationship between principal and assistant is a private one, and the powers of the B.M.A. are limited.

21. Although Executive Councils have the duty to review all consents to employ an assistant given to practitioners in their area, they and the Ministry are compelled under the terms of the act and its regulations to approach this problem from the point of view of the continuity of service to patients. Executive Councils have no power either to withdraw their consent or to modify the size of the additional list in respect of an assistant solely on the grounds of the salary and conditions of employment of a particular assistant. In these circumstances much depends on individuals and particularly on the balance of supply of and demand for assistants. Thus the conditions of employment of assistants depend on the relative ease or difficulty of establishment in practice as a principal.

22. The Subcommittee draws the attention of the Royal Commission to the fact that in some practices where there is a full list for both principal and assistant the assistant is required to do considerably more than half the N.H.S. work. This is especially likely to occur where the principal has other commitments, such as factory, police or hospital appointments, or private practice and, of course, if is the well known large list practitioner who is most likely to be offered such work, and the established practitioner with an assistant who is most likely to be able to find time for it. In some cases, the assistant may in fact be looking after more than a full list for a single-handed practitioner. The Subcommittee considers that where a principal has substantial outside commitments, the extra list permitted in respect of an assistant should be reduced considerably below the normal maximum (see paragraphs 44 and 45). Since this is a matter which affects patients as well as the assistant, Executive Councils already have power to make such a reduction and the Subcommittee hopes that this power will be fully used.

23. The Sub-committee considers that everything possible should be done to facilitate establishment in practice as a principal. There will always be practices in which an assistant is required, for varying periods, in which no partnership is likely to materialise, but this matters little to the assistant if he can be sure

that while working as an assistant he is steadily putting himself in a better position to obtain a junior partnership or, (which is not infrequently preferred) a single-handed practice, at a time of his own choice.

ENTRY AND ESTABLISHMENT IN PRACTICE AS PRINCIPAL

24. The Council has already, in its Preliminary Memorandum of Evidence, expressed its concern at the late, and increasingly late, age at which doctors are becoming established in practice (paragraphs 99, 103).

25. It is well known that at the time of the inception of the N.H.S. and the parliamentary debates that preceded it, it was frequently stressed that the N.H.S. would help young doctors to establish themselves in general practice by abolishing the need to find capital. In fact, entry and establishment have been more difficult, uncertain and unsatisfactory since 1948.

26. By 1952 the situation had become so serious that the Government in agreeing to the submission of its dispute with the B.M.A. on the interpretation of Spens to an independent arbitrator, insisted that the distribution of the pool should be the subject of an enquiry by a Working Party, the terms of reference of which included the duty "to make it easier for new doctors to enter practice". Following the implementation of the Working Party's recommendations there was an immediate but temporary improvement (see paragraph 35).

27. The Sub-committee does not suggest that entry was ever easy—it was necessary to work for the desired result—but provided that a young doctor was willing to work as an assistant, or otherwise, for several years and save money, after a time he knew that he would be able to obtain a loan which together with his savings, would enable him to purchase a practice or a share of a practice. Practices differed in price according to income, security and district, but it was then as possible to obtain a practice as to buy a house. A reasonable choice of practices existed; within limits, the doctor could buy a practice when and where he wished.

28. Since 1948 the young doctor has not been able to plan his future in the same way. He has much less choice when and where he should set up in practice.

Executive Council Vacancies

29. A doctor usually has to apply for several executive council vacancies before he is selected. The average number of applicants for Executive Council vacancies in 1957 was 35 (see Ministry of Health Annual Report, 1957, Table J). If a doctor is selected, even if the practice is not what he wanted, he will probably take it, being afraid he will not be offered another, for at least he has an income and some security. The unsuccessful applicants must continue their search.

Entry as an Assistant with view to Partnership

30. Alternatively he may take an assistantship with view to partnership. If the partnership does not materialise he has not only made no further progress towards establishment as a principal; his greater age may prove a disadvantage when he next applies for a post and he may be precluded from practising again in the area for some years by the terms of a restrictive covenant.

Starting a new Practice

31. Thirdly, he may attempt to set up a new practice, usually with an Initial Practice Allowance. This is a risky venture except on a new estate where such openings are usually granted only by selection by the executive council.

32. "Self-establishment" with the help of Initial Practice Allowances in areas considered under-doctored has declined. The Sub-committee has welcomed these Allowances and submits three reasons why they have not been fully taken up. First is the difficulty in obtaining capital for property (in this connection the Sub-committee would emphasise that a doctor having no income other than an Initial Practice Allowance is unable to obtain a mortgage or bank loan, and in fact, an Initial Practice Allowance is useful only to the doctor who already possesses sufficient capital to buy a house or who can find a suitable house to rent), second is the fact that many municipal housing schemes have been completed and their medical requirements met, and third is the fact that the number of areas defined by the Medical Practices Committee as under-doctored has decreased considerably (see Medical Practices Committee's Report).

33. Thus as a rule the doctor has little influence over his future, the major decision being made by executive councils or established doctors. Before a practice or partnership is obtained, there is often a long period of complete uncertainty, for the doctor no matter how hard he works, cannot be sure that he is making progress towards obtaining his own practice or a share in a partnership. Afterwards, he will have very great difficulty in changing his area of practice, should he so wish.

34. Figures for the numbers of doctors admitted each year to the Medical Register, the numbers admitted as principal to the Medical List and the average size of list are available and are shown in the subsequent paragraph. Figures for the numbers of principals on the Medical List, the annual increase and the annual percentage increase are given in Table 3 of the appendix together with another, Table 4, showing changes in age structure and size of list from 1955 to 1957.

35.	Year	<i>Number of Doctors admitted to Medical Register</i>		<i>Number of Doctors admitted to Medical List</i>	<i>Average size of List</i>
	1947	2,787			
	1948	3,968			
	1949	3,109			
	1950	3,160		1,210	
	1951	3,075		1,079	
	1952	4,493		1,100	2,436
	1953	507		1,568	2,324
	1954	2,222		1,176	2,293
	1955	2,992		990	2,283
	1956	3,113		960	2,272
	1957	3,226		936	2,273

36. The above figures show a continuing decline in the numbers of new principals in general practice each year since 1953.

Note: They do not take into account the possible effect of the 10 year qualifying period for supernumeration ending in July, 1958.

37. The figures (England and Wales) for the population since 1952, the number of principals in the N.H.S. and the ratio of population to the number of principals are as follows:

Year	Population (000's)	Total number of Principals (England and Wales)	Population per Principal
1952	43,995	17,204	2,555
1953	44,109	18,010	2,449
1954	44,274	18,482	2,396
1955	44,441	18,783	2,366
1956	44,667	19,082	2,341
1957	44,907	19,343	2,322

It will be seen that the figures for the population per principal has fallen very slowly since 1954. The Sub-committee considers that in order to permit a steadily rising standard of general practice this ratio should fall considerably more rapidly, and therefore the total number of principals should increase more rapidly than it has in the last few years.

38. The attention of the Commission is directed to the situation that may arise in 1960. If National Service ends approximately 700 doctors will become available for civilian employment in 1960 and another 700 in 1961, together, of course, with those newly registered each year. Many of these will seek to enter general practice.

39. The Council has expressed its concern at the difficulty which faces doctors wishing to move from one area to another (para. 110 and "Entry into General Medical Practice" by Dr. L. S. Potter, page 14, first paragraph). Since a doctor is compelled to live close to his practice, the ability to change his area of practice is of greater importance to him than to persons in most other walks

of life—yet the doctor finds it more difficult than most other persons to move (Preliminary Memorandum, para. 110).

40. In the Sub-committee's opinion there are three reasons for the undoubted recent difficulty of entry into practice for the average junior member. These are:

- (i) The reduction since 1951 in the value of the money available for general medical services;
- (ii) The existing schemes of distribution of this money; and
- (iii) The prohibition since 1948 of the sale of goodwill.

Goodwill

41. It has been held by the courts that goodwill of medical practices still exists—it is merely its sale which the N.H.S. Act has prohibited. The general practitioner is in the anomalous position of being the only self employed person in the country who is forbidden to buy or sell goodwill (even the dentist in the N.H.S. can sell goodwill, although he has a superannuation scheme as well). Yet the general practitioner, being self employed, must have obtained his goodwill by some method. In fact the lengthy and detailed provisions of the N.H.S. Act, and the penalties prescribed, suggest that the sale of goodwill is natural and therefore difficult to eradicate. Prohibition of the sale of goodwill has resulted in:—

- (a) Lack of incentive to older doctors to retire before their practices have deteriorated.
- (b) Reduced incentive to older doctors to take a junior partner.
- (c) Distortion of the relationship between assistant with view to partnership and principal. Before 1948, an assistantship with view was a genuine trial partnership, since the increase in income and security for the assistant and loss of income for the principal which occur when the partnership is confirmed, were compensated by a payment from assistant to principal and so the partnership had balanced advantages and disadvantages for both parties. Since 1948, the immediate advantages to the assistant and disadvantage to the principal can no longer be compensated by any payment, although this is to a considerable extent offset by the fact that as a rule the junior partner will do half or more than half the work for a number of years for a third of the partnership income (see para. 60). Hence the assistant tends to desire a partnership too readily, while a principal tends not to desire one readily enough.
- (d) Distortion of relationship between senior and junior partner, the latter having little or no "stake" in the practice and remaining psychologically in the position of an assistant (see para. 58).
- (e) Abolition of choice by younger doctor, subject to availability and price of practices, and substitution of choice by selection committee.
- (f) Severe restriction of freedom of movement, common to all doctors, so that younger doctors are unwilling to settle in less attractive areas, realising that they probably will be compelled to remain for the rest of their lives.

42. The Association in 1954 decided that the restoration of sale of goodwill was impracticable.

43. The Association has never considered the restoration of sale of goodwill as undesirable and some would say that its prohibition has caused great difficulties, not least to those who might have expected to benefit, namely the younger practitioner wishing to establish himself in general practice.

Size of Lists

44. Within the framework of the N.H.S. Acts the Sub-committee feels that the main measure which would help the younger doctor attempting to establish himself in general practice would be a reduction in the maximum size of list for a principal and a corresponding reduction in the extra permitted list for an assistant. Since 1952 when the maximum size of list for an established principal was reduced from 4,000 to 3,500 there has been a steady fall in the ratio of the size of the population to the number of general practitioners, due to a

greater increase in the latter than the former. The ratio in 1952 was one N.H.S. general practitioner to every 2,555 persons. In 1957 it was one N.H.S. general practitioner to every 2,322 persons. (See para. 37.) The Sub-committee wishes to point out that some reduction of maximum list would cause no injustice to the full list doctor. Although if there were no simultaneous increase in the betterment factor such a doctor would suffer a small immediate fall in income, he alone of general practitioners has already been partially compensated for the effects of the fall in value of money by the increase in the Pool due to the increase in the number of principals taking part in the N.H.S., without taking into account either the 5 per cent. and 4 per cent. interim increases in net income, or the increasing payments in respect of expenses. Thus while for the average general practitioner the increase in net income per patient due to the increase in the number of principals and the resulting increase in the total net income of the profession has been exactly offset by a fall in the number of patients on his list, the practitioner who has retained a full list since the Danckwerts Award has had an increase in income per patient without any offsetting factor other than the fall in the value of money which has affected all practitioners. The profession as a whole has suffered a reduction of 29 per cent. in the purchasing power of its income since Danckwerts, partially offset by the 5 per cent. and 4 per cent. interim increases—the full list practitioner has suffered much less because he has gained up to 10 per cent. by the increased payment in the final settlement, apart from the 5 per cent. and 4 per cent. interim increases which apply to all practitioners.

45. The assistantship system as has been pointed out above permits a principal with a full list for himself and a full extra list for his assistant to undertake other remunerative work outside his N.H.S. practice, while the greater part of the N.H.S. work of the total list is done by the assistant. It is the well known large list practitioner who is most likely to be offered such work, and of large list practitioners, it is those with assistants who are most likely to be able to find time for it. As a result such work is not usually available for the small list practitioner who is attempting to establish himself. The Sub-committee draws attention again to its proposal given in para. 22.

46. One further difficulty facing the doctor attempting to establish himself in practice is the cumbersome administrative procedure necessary before a patient who has not changed his address can change his doctor, and more important the fact that this procedure has given some less well educated patients the impression that change of doctor is impossible. The Sub-committee considers that the disadvantages of the present procedure outweigh its advantages, and suggests that the procedure be simplified.

47. The Sub-committee considers that the time has come for a reduction of the figures for doctor/population ratio used by the Medical Practices Committee as criteria for determining whether or not extra doctors are needed in an area. Such a reduction would lead to an increase in the number of initial practice allowances available and thus would help to facilitate establishment in practice.

48. Statistics of the Initial Practice Allowance Scheme are shown below:—

<i>Year</i>	<i>Number of Doctors</i>	<i>Total Cost</i>	<i>Average Cost for doctors in receipt of I.P.A.</i>
		£	£
1953-54		160,931	
*1954-55	256	108,151	422
1955-56	217	75,025	350
1956-57	189	46,149	249
1957-58	131	41,431	316
1958-59 (estimated)	100	30,076	300

The Subcommittee considers that the state obtains very good value from the I.P.A. scheme.

* *Note:* The numbers are for the years ended 31st December and the costs are in respect of the financial years.

PRACTICE EXPENSES

49. The Assistants and Young Practitioners Sub-committee considers that the present method of distribution of payment for expenses (i.e. together with the capitation fee, irrespective of the size or circumstances of the practice) is unsatisfactory. An improvement of this system would be a considerable help to those attempting to establish themselves as principals in general practice.

50. The Sub-committee and the members whom it represents have had to endure with forbearance some hard knocks from the rough justice which the present expenses reimbursement system is said by the Council to afford to all. (Fourth Supplementary Memorandum para. 30.) The Sub-committee expresses the view that principals with lists in the lower ranges receive inadequate and inequitable reimbursement of expenses.

51. The failure to pay loading below the 501st patient to those who are maintaining surgery premises and providing unrestricted general medical services has always been regarded as a hardship on unestablished practitioners. This exaggerates the present unsatisfactory distribution of expenses.

52. The Council in its fourth supplementary Memorandum of evidence to the Royal Commission (paras. 31 & 32) has pointed out that Initial Practice Allowances, Supplementary Annual Payments and Hardship Payments make a contribution towards the expenses of some small list doctors. The Royal Commission's attention is drawn to the very small numbers of doctors who receive Initial Practice Allowances, Supplementary Annual Payments and Hardship Payments all generously increased after the 5 per cent. interim adjustment of May 1957 and increased by 4 per cent. from 1st January 1959.

Year	I.P.A.		S.A.P.		Hardship Payments	
	No.	Cost	No.	Cost	No.	Cost
*1956 ...	189	£46,149	290	£75,761	9	£2,901
1957 ...	131	£41,431	284	£77,332	4	£2,219

* Note: The numbers are for the years ended 31st December and the costs are in respect of the financial years.

53. In 1957 there were 1,014 doctors in single-handed practice with less than 1,000 patients and providing unrestricted medical services.

54. The statement that practice expenses are somehow paid by the final settlement, larger for those already most favourably rewarded financially, rubs salt in the wounds of lower list principals.

55. It has been pointed out by the Council that the present method does not attempt to reimburse to each doctor the exact annual expenses which he has incurred. While the Sub-committee believes this to be impracticable and in fact, undesirable, in view of the consequences pointed out in the Fourth Supplementary Memorandum, para. 33, it considers that so long as the capitation fee system persists, each doctor should receive a standard capitation fee for each patient, representing net income, together with an "expenses" capitation fee, which would vary according to the size and circumstances of the practice. It is understood that practices are already classified into about 10 groups according to size and type, each with different expense ratios and this classification could be used. In practice the present system could be used, making the adjustment in the supplementary payment. This method although not entirely accurate, is thought by the Sub-committee to be less unjust than the present arrangement.

56. The Sub-committee hopes that the Royal Commission will go as far as possible in recommending an equitable scheme of distribution of the money needed for expenses.

PARTNERSHIP PRACTICE

57. Partnership practice has been increasing during recent years and is, of course, encouraged by the fact that formation of a partnership is the only method now available whereby a principal can retain control of his good will, while small single-handed practices which formerly would have been sold intact tend

to wither away, and be redistributed, rather than advertised. The "notional list" system has also to some extent encouraged the development of partnerships.

58. There are certain advantages in partnership practice to both partners as well as to the patients. However, it is essential that the prospects and status of the junior partner should be secure and that he should not be regarded as an assistant under another name. It has already been shown (para. 41 (c)) how the prohibition of sale of good will has disturbed the relationship of "assistant with view" to the principal, the assistant having little to offer and much to gain, the principal having little to gain and a definite part of his income to lose. This disturbance is liable to persist after formation of the partnership (see para. 41 (d)), leading to a sense of inequality between the partners, a feeling of injustice on both sides, and to the feeling, on both sides, that the incoming man, having paid nothing to enter the practice, has no "stake" in it, and is psychologically in the position of an assistant. Many of these problems are psychological and intangible, but they are nevertheless real, and cannot but harm the personal relationship which is the basis of any partnership.

59. In some "partnerships" the disparity in status of the two partners is such that the junior partner is paid a salary. The Sub-committee considers such an arrangement inherently undesirable, and not a true partnership. It considers that "loadings" should not be payable in respect of such a junior "partner".

60. The Sub-committee wishes to point out that, in many partnerships, the junior partner, even after a preliminary assistantship, is expected to do more than half the work for a variable number of years for a third of the partnership income with no prospect of financial capital gain. This situation, although only to be expected since the junior partner has no other way of paying for his secure income and compensating the senior partner for his loss of income, would appear to be virtually a sale of good will, and seems incompatible with the intention of the N.H.S. Act.

61. Few single-handed practitioners work in complete professional isolation except possibly in remote rural areas. The majority take part in rota arrangements which allow each member some time off duty, cover short periods of illness, encourage clinical discussions and facilitate the obtaining of a second opinion. Thus most of the advantages of partnership may be obtained, while a more personal service may be given.

ENCOURAGEMENT OF QUALITY WORK

62. The Sub-committee expresses the view that the size of list is not, by itself, a satisfactory measure of a doctor's ability. Apart from ability there are other factors which influence the size of a doctor's list such as the situation of the practice premises, the density of the population, the local ratio of doctors to population in the district, and the help of an assistant.

63. The Sub-committee would prefer that remuneration should bear more immediate relation to work actually done, for example in midwifery, emergency work out of hours and co-operation with hospital, specialist and local authority services.

64. For this reason, the Sub-committee would welcome the consideration of alternative methods of remuneration, from which a choice could be made by agreement between doctor and patient. Such methods might include the capitation fee system or the item of service system and an insurance method of remuneration. The Sub-committee does not favour the salary method in general practice.

65. The Sub-committee shares the Council's doubts as to the value of any system of "Merit Awards", and feels that any system where extra income is the result of approval by a committee might well lead to nepotism, favouritism, corruption and the destruction of what remains of the traditional independence of the general practitioner, so necessary to the proper practice of medicine.

66. The Sub-committee stresses the importance of regular post graduate study to maintain standards of clinical work in general practice.

67. The Sub-committee hopes that the Royal Commission on Remuneration will produce a financial framework allowing all doctors to practice their profession in complete freedom, subject only to necessary professional discipline.

68. The Sub-committee considers that there is danger to this freedom in any system in which the greater part of the profession's income comes directly from the State. While realising the necessity for parliamentary control of public expenditure the Sub-committee regrets that so much of the detailed administration of the service should still lie within the arena of party politics.

69. With better apprenticeships, easier entry as principal, proper repayment of expenses, reward for quality work in general practice and full professional freedom, then indeed younger doctors will welcome the future.

APPENDIX

Table 1

ANALYSIS OF PRINCIPALS BY AGE AND SIZE OF LIST

Age	Size of List				
	Under 1,500	1,501-2,500	2,501-3,600	3,601 and over	Total
35 years and under...	2,097	834	568	187	3,686
36-45	1,288	1,593	1,863	942	5,686
46-55	788	1,269	1,639	1,079	4,775
56-65	812	1,187	1,177	1,077	4,253
66 years and over ...	575	409	244	103	1,331
Total	5,560	5,292	5,491	3,388	19,731

From Ministry of Health Report, 1957, Appendix XVII, Table C.

For the purpose of this table, the size of list of a doctor in partnership is the actual size of his own list.

Table 2

ASSISTANTS

Trainee Assistants	349
"Permanent" Assistants:	
Under 30 years	580
31-45	499
36-40	159
Over 40 years	227
	<u>1,814</u>

Ministry of Health Report, 1957, Appendix XVII, Tables A and E2.

Table 3
NUMBERS OF PRINCIPALS, 1952 TO 1957

Year	Total number of Principals (England and Wales)	Annual Increase	Annual Percentage Increase	Population (England and Wales)	Population per Principal	Average Size of List	Approximate Percentage of Population on Doctors List
				(000's)			Per cent.
1952 ...	17,204			43,955	2,555	2,436	95.34
1953 ...	18,010	806	4.7	44,109	2,449	2,324	
1954 ...	18,482	472	2.6	44,274	2,396	2,293	
1955 ...	18,783	301	1.6	44,441	2,366	2,283	
1956 ...	19,082	299	1.6	44,667	2,341	2,272	
1957 ...	19,343	261	1.3	44,907	2,322	2,273	97.89

Ministry of Health Reports: 1956, page 52; 1957, page 60.

Table 4
CHANGES IN SIZES OF LISTS AND AGES OF DOCTORS
BETWEEN 1955 AND 1957
Difference between figures at 1st July 1957 and 1st July 1955

Age	Size of List				
	Under 1,500	1,501-2,500	2,501-3,600	3,601 and over	Total
35 years and under...	- 63	- 76	- 62	- 73	- 274
36-45 ...	+ 38	+ 123	+ 113	+ 32	+ 306
46-55 ...	- 12	- 111	- 101	- 151	- 375
56-65 ...	+ 112	+ 207	+ 267	+ 517	+ 1,103
66 years and over ...	- 5	+ 19	+ 14	+ 33	+ 61
Total ...	+ 70	+ 162	+ 231	+ 358	+ 821

From Ministry of Health Reports: 1955, Appendix XVIII, Table C, page 197; 1957, Appendix XVII, Table C, page 200.

Extra tables based on material from Manchester and Scottish Offices of Medical Practices Advisory Bureau and Dr. English's figures.

For the purpose of this table, the size of list of a doctor in partnership is the actual size of his own list.

Table 5

ASSISTANTSHIPS IN LONDON AND THE HOME COUNTIES

*Replies to an inquiry conducted by a member of the Sub-committee
representing assistants in the area*

Assistant	Salary received in cash	Gross income	Any increments	Satisfied with entry into General Practice	Is wife expected to carry out practice duties
	£	£			
1	1,000	1,250	No	No	No
2	732	1,200	50	Yes but has failed to get view	Yes
3	722	950		No	Yes
4	970	1,050	Yes	Yes but impossible if married	
5	1,200	1,225	100	Yes	Yes
6	840	1,100		Yes	No
7	1,100	1,400	100	Yes	No
8	900	1,100	No	Yes on the whole	Yes
9	1,300	1,550	50	Yes	No
10	960	1,200	No	Yes not quite	
11	990	1,200	No	Yes	No
12	1,200	1,200	No	Yes	No
13	1,870	2,000	Yes	Yes	Yes
14	1,200	1,350	No	Not quite	Yes
15	1,050	1,200		No	No
16	900	1,050	No	No	
17	1,150	1,450	Yes	No	No
18	800	1,218		No	Yes
19	1,350	1,350	Yes	No	Yes
20	850	1,000	No	Yes previously dissatisfied	Yes
21	1,200	1,200		No	
22	1,100	1,250	100	No	
23	900	1,200	No	No	Yes and cleans
24	960	1,300	No	No	
25	840	1,040	50	No	No
26	1,475	1,475	No	No	No
27	1,176	1,176	Yes	No	Yes
28	1,350	1,350	No	No	
29	1,150	1,250	No	No	Yes
30	1,000	1,400	No	No	No
31	1,200	1,280		Yes	No
32	900	1,050	No	No	Yes
33	1,100	1,400	No	Yes	Yes
34	1,585	1,785	Yes	No	
35	1,100	1,350	Yes	No	No

Number of full-time assistants' replies ...	...	...	35 (no trainee assistants)
Average Gross income ...	...	...	£1,260
Average Nett income ...	...	...	£1,089

Table 6

ASSISTANTSHIPS IN SOUTH EAST ENGLAND

Replies to an inquiry conducted by a member of the Sub-committee representing assistants in the area

	Years Since Qualification	Years Employed as Assistant	Number of Posts held as Assistant	Gross Salary including Allowances	Allowances Received	Nett Salary	? View	Agreement with Association's Fourth Supplementary Memorandum of Evidence to Royal Commission
1	8½ yrs.	2½ yrs.	3	£ 1,100	Car £200, Flat £182	£ 718	No	No
2	8 yrs.	3½ yrs.	2	1,200	Account £104	1,000	No	No
3	4½ yrs.	2 yrs.	2	1,200	Car £200	1,000	No	No
4	6 yrs.	1½ yrs.	1	1,200	Car £200		No	No
5	2 yrs.	6 mths.	1	1,080	Car £150	900	No	No
6	5 yrs.	1½ yrs.	2	1,150	Car £150, Telephone and Petrol.	850	Yes	No
7	3 yrs.	1 yr.—	Trainee Assistant not included.					
8	5½ yrs.	3 yrs.	3	975	Unfurnished Accommodation.	850	? View	No
9	4 yrs.	2½ yrs.	2	1,370	Car £220		Yes	With Reservation
10	3½ yrs.	6 mths.	2	1,300	Car £250 and Telephone.	1,140	Yes	No
11	6½ yrs.	2½ yrs.	1	1,000	Nil		Yes	No
12	10 yrs.	5½ yrs.	3	1,050	Car and Telephone.	850	No	No
13	8 yrs.	2 yrs.	2	1,150	Rent and Rate-free House £150.	1,000	No	No
14	5½ yrs.	1 yr.—	Trainee Assistant not included.					
15	5 yrs.	2 yrs.	1	1,000	Car £200	800	No	Not fully
16	7 yrs.	3½ yrs.	2	1,310	Car and Petrol £312.	1,000	Yes	No
17	15 yrs.	2 yrs.	1	1,236	None	936	Possibly	No
18	17 yrs.	11 yrs.	2	1,400	Car £200, House rent free (rates not allowed).		Possibly	No
19	Is not eligible—as he is a long-term locum at present.							
20	Is not eligible—part-time.							
21	9 yrs.	5½ yrs.	3	1,200	Nil		No	No
22	6½ yrs.	2 yrs.	2	1,100	Car	900	Yes	No
23	5 yrs.	3 yrs.	2	1,170	Car £144, Account £220.	800	Yes	No
24	6 yrs.	3½ yrs.	3	1,000	Account, Telephone.		Yes	No
25	8½ yrs.	4 yrs.	2 (T)	1,200	Telephone and Maternity fees.		No	No
26	9½ yrs.	5 yrs.	1	950	Car and Telephone.	700	Yes	No
27	10 yrs.	4½ yrs.	4	1,150 ("Below")	Telephone, Accommodation and Rates.		No	No

	Years Since Qualification	Years Employed as Assistant	Number of Posts held as Assistant	Gross Salary including Allowances	Allowances Received	Nett Salary	? View	Agreement with Association's Fourth Supplementary Memorandum of Evidence to Royal Commission
28	4 yrs.	15 mths.	2	£ 1,050	Car £200, Account £150.	850	Yes	?
29	5 yrs.	1 yr.	2	1,250	Car £200	1,050	Yes	No
30	8½ yrs.	1 yr.	1	1,350	Telephone Account Provided.	1,200	No	No
31	6 yrs.	1 yr.	2	1,250	Rent free being £150, Car £150.	750	No	No
32	Not included—part-time.							
33	2½ yrs.	1 yr.	1	1,225	Flat £200 over Surgery, Telephone, Garage, Electricity.	1,025	No	No
34	Not included—Locum only.							
35	5 yrs.	2 yrs.	2	1,250			Yes	Yes
36	7 yrs.	2½ yrs.	3	1,100	Car £150	950	No	No
37	6½ yrs.	2½ yrs.	2	1,100	Car £180	920	Yes	No
								Misrepresents.
38	3½ yrs.	2½ yrs.	2	1,150	Nil		No	No
39	6½ yrs.	2½ yrs.	2	1,200	Nil		?Yes	Yes
40	29 yrs.	9 yrs.	1	1,150	See Letter		No	No—Betrayed.
41	7 yrs.	3½ yrs.	3	1,200	Car £200	1,000	Yes	Yes
42	7½ yrs.	3 yrs.	2	1,210	Car £150	1,060	No	No
43	14 yrs.	10 yrs.	2	1,200	House with Garage.	1,070	No	No
44	5½ yrs.	1½ yrs.	2	1,200	Petrol and Telephone.	985	Yes	No
45	4 yrs.	9 mths.	1	1,150	Nil	1,000	Yes	Yes
46	6 yrs.	1 yr.	2	1,250	Nil		No	No
47	6½ yrs.	1 yr.	1	1,100	Car £150	950	Yes	No
48	2½ yrs.	6 mths.	1	950	Car £150	800	No	No
49	6½ yrs.	2½ yrs.	4	1,200	Nil		Yes	No
50	7½ yrs.	4 yrs.	3	1,200	Free Furnished House and Heating £225, Telephone £15.	900	Yes	No
51	7 yrs.	2½ yrs.	2 (T)	1,050	Car £150	900	No	No
52	4 yrs.	1½ yrs.	2 (T)	1,150	Car £250 p.a., House £50 p.a.	850	No	No
53	9½ yrs.	1½ yrs.	2 (T)	1,200	Car £200	1,000	Yes	No
54	6½ yrs.	2½ yrs.	2	1,200	Nil		No	No

MEMORANDUM OF EVIDENCE--PART II

At the Comitia on 25th April, 1957, the President announced the setting up of a nucleus committee to prepare the draft evidence to be submitted to the Royal Commission on Doctors' and Dentists' Remuneration.

The following Committee was appointed:

- Dr. R. Platt, President.
- Lord Moran.
- Sir Russell Brain, Bt.
- Sir Harold Bolddero.
- Dr. T. C. Hunt.
- Dr. T. F. Fox.
- Dr. M. I. A. Hunter.

In Part I of its evidence which has already been sent to the Royal Commission the College dealt with some matters of principle. It now submits answers to the specific questions raised by the Royal Commission.

Q. (i) The quality and quantity of recruits (a) offering themselves, and (b) accepted for training as medical students.

QUALITY OF RECRUITS

(a) Offering Themselves

Compared with before the war, the quality of the average applicant has certainly fallen. A far larger number apply, and a larger proportion are unsuitable. The College attributes the increase in numbers entirely to the improved chances of obtaining grants.

(b) Those Accepted by Medical Schools

Quality is a matter of opinion; but the College is fortunate in having at its disposal the opinions of nearly all the Deans of Metropolitan Medical Schools. Of these, none thinks that the standard of his entrants has risen since 1946, and one or two think it has fallen; but the great majority can detect no change. Similarly, the Headmasters' Conference, while emphasising the difficulty of obtaining evidence, do not think there has been noticeable deterioration.

QUANTITY OF RECRUITS

The College is greatly indebted to the "Conference of Deans" (twelve Metropolitan Medical Schools) for allowing it to cite the following figures collected from their schools.

(a) Offering Themselves

Over the five years 1950-55 the number of recruits offering themselves for the whole medical course in London has hardly varied. Counting only once those who apply to more than one London School, the number is about 2,650 annually.

(b) Those Accepted by Medical Schools

Similarly, in these five years, the number admitted has remained roughly constant at about 750.

These figures take no account of men and women who do their pre-clinical work at other universities, such as Oxford and Cambridge, and come to London for their clinical studies.

Q. (ii) The Quantity and Quality of Newly Qualified Doctors

QUANTITY

The numbers of newly qualified doctors registered by the General Medical Council are distorted in 1952 and 1953 by the introduction of provisional

registration in the Medical Act of 1950. But since 1954, for England, Scotland and Ireland taken together, the numbers provisionally registered have been remarkably even.

1954	...	...	...	...	...	...	2,261
1955	...	...	...	...	...	...	2,225
1956	...	...	...	...	...	...	2,302

QUALITY

Probably the general opinion is that the quality of the newly qualified doctors today differs little from their quality say ten years ago.

Q. (iii) Wastage of Men and Women during Training and in the First Few Years after Qualification with any Remarks on Incidence and Causation

Wastage of Men and Women during Training

For the purpose of this answer the College will assume that "training" begins at the commencement of courses of instruction for the examinations in anatomy and physiology (University of London, 2nd M.B.). Though some medical students take their pre-medical course at school, all of them have to enter a Medical School to study anatomy and physiology. Thus we get a true picture.

The *wastage among men is 4.78 per cent and among women is 8.45 per cent, and the wastage of men and women together is 5.58 per cent. (Women at present form about 20 per cent of the medical student population.)

This wastage is due to many factors, the main ones being:—

- Repeated failure in examinations,
- Psychological unsuitability to become doctors,
- Serious ill-health,
- Among women, early marriage.

Wastage of Men and Women during the First Few Years after Qualification

There are no reliable figures known to us but the College believes the wastage at this stage to be very small. Among women doctors marriage leads to a small definite loss—but more often to intermittent practice of medicine.

Immediately after qualification all doctors have to do a year's work as House Officers in hospitals. A very few find themselves unsuited to the responsibilities of clinical work. Most of these eventually choose medical work other than clinical, but it should be recorded that at this stage psychological breakdown occurs from time to time.

Q. (iv) The Cost and Duration of Training and the Extent to which the Cost is or should be met from Grants (including both the Adequacy of the Grants and the Proportion of Students Receiving Them)

Duration of Training

The medical curriculum proper covers five years, but must be preceded by one year of pre-medical education culminating in an examination in physics, chemistry and biology (in the University of London, 1st M.B.). Moreover, after completing the curriculum proper and passing a "final" examination (in the University of London, 3rd M.B.) there is still a compulsory year of residence in hospital before the young doctor is fully registered and allowed to practise independently. The College would like to add that very few forms of medical practice can be properly undertaken without further postgraduate study and experience; in the case of a consultant this will normally last at least seven years, and latterly the "training" period for consultants has more often been ten, fifteen or even twenty years.

* Report of the Committee to Consider the Future Numbers of Medical Practitioners and the Appropriate Intake of Medical Students, 1957, p. 31.

Cost of Training

The cost of undergraduate training can, for convenience, be divided under two broad headings:—

(a) Fees of Medical Schools, subscriptions to athletic and social clubs and examinations.

(b) Cost of a student's maintenance.

(a) The College submits two examples which are fairly typical, one from London and the other from Liverpool.

	London	Provinces
	£	£
(i) Aggregate of annual fees for six years* ...	360	276
(ii) Subscriptions to clubs for six years ...	45	33
(iii) Examinations ...	47	28
(iv) Books, instruments, etc. ...	100	100
	<hr/> £552	<hr/> £437

(b) The cost of maintenance will depend on whether a student lives at home or has to pay lodging or hostel charges. In London about half the students live at home, which involves some travelling expenses.

In London the average amount spent on maintenance—including lodgings but not clothing—by those living away from home for a full course of six years is between £1,500 and £2,000, and in the provinces it is between £1,000 and £1,500.

Average figures for fees and maintenance together, for six years, might thus be:—

(a) In London, £2,300.

(b) In the provinces, £1,700.

Proportion of Students Receiving Financial Assistance

The proportion of medical students who are supported by grants is relatively low. The Report on Inquiry Commissioned for the Mountford Committee, 1957, states that 61 per cent. of male medical students receive some financial assistance, while 81 per cent. of men in all faculties do so.

Adequacy of Grants

In some cases the grants suffice for the stark necessities of life. On the other hand there are anomalies amounting to hardship. Parents in the middle-income groups, into which many doctors fall, are severely tested, and as stated on page 12 of Part I of the College evidence, "many, especially if they have several children, can no longer afford to give a boy five or six years' unpaid training. Their income is high enough to prevent their having any of the help that other parents get from public grants, but not high enough for them to find several hundred pounds a year for six years for one child."

The best way to remove these anomalies would be to arrange that "educational expenses" incurred by parents should rank for relief of income tax.

If this suggestion is not accepted, the means test used by grant-giving bodies should be based more realistically on the parent's actual disposable resources—after he has paid tax. This realistic type of test has been adopted by some public schools in awarding their scholarships.

Another suggestion is that a student whose parent's income is high enough to prevent his receiving a grant for the first three years of his course (corresponding to the normal period of study in other faculties), should nevertheless be eligible for a maintenance grant during the clinical period, *i.e.*, the second three years of his training.

* Those who take the 1st M.B. examination from School have only five years at their University.

The grants cease on passing the final examination. While the young doctor is doing his provisional registration year in hospital he is housed and fed, and his parents need not be put to any expense. But his small salary does not allow for any luxuries, nor for being married.

Q. (v) The Position and Prospects of a Newly Qualified Doctor

Medicine is one of the few professions which requires compulsory residence after qualification for at least one year with a limited salary. The present salaries of residents are:—

House Officer

£467 10s. per annum for the first post held,

£522 10s. for the second post held.

£577 10s. per annum for the third and any subsequent post held.

Less £125 per annum for board and lodging.

Senior House Officer

£819 10s. per annum.

Less £150 per annum for board and lodging.

As family accommodation is seldom offered to junior hospital medical staff, residents who are married must provide, in addition, lodging for their wives and families. Senior house officers, and house officers after the first year, are sometimes able to live at home but, if so, they must be accessible by telephone and will sometimes need car transport. Allowance should be made for these obligatory expenses, which bear particularly heavily on married junior hospital staff and for which there is no income tax relief.

Most newly qualified men do their two years' National Service immediately after their year of compulsory house appointments. It is expected that the National Health Service, though it has at present many vacancies for house officers, may have difficulty in absorbing the influx of doctors when compulsory National Service ceases. Doctors already have difficulties in getting into general practice.

Q. (vi) Any Trend to Excessive Resort to certain Branches of the Profession at the Cost of Others

Because many general practitioners seeking assistants or partners now look askance at men with long hospital experience, there is a tendency for doctors to try to enter general practice at the earliest possible moment. Not only is this bad for the training of future general practitioners but it increases the difficulty of filling junior hospital posts especially in the provinces and rural areas. As evidence of this trend it can be stated that in a London teaching hospital the average number of applications for registrar posts has dropped in the last five years from twenty to twelve (in all specialties), and in a non-teaching hospital in London it has dropped from fifteen to ten.

Another factor which discourages recruiting to junior hospital posts is that the position of existing junior staff and their lack of prospects of advancement is well known to potential applicants.

For various reasons, doctors who take up hospital work in the hope of becoming consultants tend to choose one of the major specialties such as general medicine and surgery. While there is room for more consultants in the National Health Service, even in these major specialties, there are other specialties such as psychiatry and anaesthesia and to a less extent pathology and radiology, in which there is a shortage of applicants for consultant posts.

A suggestion has been made that junior hospital posts in peripheral hospitals should be paid at a higher rate than those in similar posts in, for example, teaching hospitals. The College is not in favour of this suggestion, but feels that greater amenities at peripheral hospitals might attract more staff to them. Apart from lack of amenities, a great deterrent to acceptance of posts in these peripheral hospitals is that young men fear that once they have accepted an appointment in such a hospital it is likely to become a dead end from which it is difficult to move forward in their career.

Q. (vii) *The Relative Advantages and Disadvantages, Financial and Otherwise, of Service as:—*

- (a) a principal in single-handed general practice,
- (b) a partner in general practice,
- (c) a whole-time consultant in the National Health Service,
- (d) a part-time consultant with the maximum number of sessions,
- (e) a part-time consultant with only a few sessions,
- (f) a Senior Hospital Medical Officer,
- (g) a doctor in any other sort of practice or employment.

(a) No comment.

(b) No comment.

(c) *A whole-time consultant in the National Health Service.*

Compared with general practitioners, consultants as a body are at a disadvantage in that they start their careers as consultants at a later age and retire earlier. They have to retire from hospital practice at 65 years of age, whereas there is no age limit for general practitioners.

The whole-time consultant has the advantage of security. He has consulting rooms and a more or less adequate secretarial service provided in hospital. The relevant part of Spens Consultants report has never been adequately implemented. Namely: "all specialists engaged either whole-time or part-time in the service, should be paid, in addition to the remuneration recommended, any sums which represent expenses necessarily and reasonably incurred in the course of their work." The Spens Committee envisaged that these would "include car expenses; expenses of travel apart from the use of a car; the cost of renewal of instruments and other equipment; the cost of books and journals, preparation of scientific papers, and subscriptions to professional societies; printing, stationery, postage and telephone costs; expense of attendance at national and international professional meetings; and the expenses of visiting hospitals and clinics at home and abroad, and entertaining visiting colleagues."*

Some whole-time consultants attend only one hospital and its committees, and the time they spend in day to day travel and non-medical work may therefore be small. On the other hand many whole-time appointments, especially in the narrower specialties and in the provinces, are made to a group of hospitals rather than to one. Those consultants who need cars for travelling between hospitals and for domiciliary consultations should be treated in the same way as regards tax and allowances for travelling as their part-time colleagues.

The whole-time consultant has the disadvantages of a fixed salary with few income tax allowances for necessities. The present income tax regulations deter men from accepting full-time consultant posts.

The whole-time consultant is obliged to carry out eight domiciliary consultations per quarter before being paid for any.

On retirement he is at a disadvantage as compared with his part-time colleague established in private practice, which may continue; but this is to some extent compensated for in that he will receive a larger pension. Moreover, private practice rapidly diminishes on retirement from hospital.

(d) *A part-time consultant with the maximum number of sessions*

The part-time consultant with maximum sessions has also the advantage of security. In addition, he has a right to do private practice and so earn private fees. At present private practice carries with it more allowances for professional and travelling expenses. He has the disadvantage of having to provide a consulting room and secretary for his private practice. No consultant, whether whole- or part-time, is paid for domiciliary visits in excess of 200 per year.

* Report of the Inter-departmental Committee on the Remuneration of Consultants and Specialists, page 15, para. 8; page 13, para. 16.

There should be no limit to the number of domiciliary visits for which payment is made. The payment for domiciliary visits should take time as well as distance into account, as some rural visits may occupy half a day of a consultant's time.

Although a part-time consultant attends a hospital for a certain number of sessions his responsibility for his patients does not cease when he leaves the hospital. In this respect there is no difference between whole-time and part-time work.

In many parts of the country the advent of the National Health Service has very greatly reduced private practice. This means that a man who has served only ten years as a part-time consultant and is about to retire may suffer considerable hardship. His pension is small owing to his short service, and he may be unable to supplement it adequately. The College suggests that special consideration should be given to the problems of such a man. This difficulty will disappear when the service has been in existence for a sufficient length of time.

(e) A part-time consultant with only a few sessions

The average number of sessions held by part-time consultants is believed to be between seven and eight, and that there are not many consultants with few sessions apart from those in undergraduate teaching hospitals. However, difficulties do arise for the young consultant beginning practice. A senior registrar who becomes a consultant by obtaining a post with only a few sessions will be financially poorer than he was as a senior registrar. He has then to collect as many sessions as he can in order to compensate himself. As proof of this, it can be observed that when advertisements appear offering a few consultant sessions, they tend to be taken up by men who are already consultants. Geographical positions of hospitals may require much time to be spent in travelling by men with few sessions or in a narrow specialty.

The advantage and disadvantage of service as a part-time consultant with few sessions depends upon the density and prosperity of the local population. While in a large city he has a chance of earning fees from private practice, which may even continue after retirement from the Health Service, in less populous areas he has virtually no chance of private practice to supplement his basic salary although he has comparable expenses. It is suggested that in these areas no part-time consultant appointment should be of less than seven sessions.

(f) A Senior Hospital Medical Officer

The senior hospital medical officer has some advantage of security, but many disadvantages. In most specialties he has little hope of obtaining a consultant appointment. His salary does not increase adequately with experience. He has also the disadvantage of inadequate professional status after many years of experience. The majority are full-time and debarred from private practice.

On the other hand if this grade did not exist there would be no career in hospitals for men who wished to work there but were not of consultant status. In some specialties this grade is necessary for the work of the hospitals. Senior hospital medical officers should not, however, be called upon to do work which should properly be undertaken by consultants.

(g) A doctor in any other sort of practice or employment

The whole-time member of a university staff has the advantage of research facilities and teaching experience. Against this must be set a slightly lower salary, less allowance for travelling and little opportunity for advancement to professorial chairs. Fewer professional expenses are allowed to rank for tax relief.

Other categories of employment may be whole-time private practice, work under local health authorities, in the Civil Service, or in industrial medicine, or whole-time research. At present salaries and responsibilities in these occupations differ considerably.

The great majority of men who qualify as doctors practise their profession in the National Health Service.

Q. (viii) The Difficulties Encountered by Members of the Registrar Grades

There are two grades of registrars.

The senior registrar grade is a training grade for a consultant post, whereas the registrar, although receiving valuable training and experience, is not considered a trainee consultant. Nevertheless, aspirants to consultant rank must pass through this grade before being senior registrars.

The basic difficulty encountered by the senior registrar grade is the partial breakdown of the planned ladder of promotion to consultant rank and the lack of provision for alternative work in the Health Service for those who fail to attain this rank.

Senior registrars might be described as trainee consultants, and are used by the Health Service to do much of the indispensable routine work of the hospitals. They often carry heavy responsibilities yet have uncertain hope of eventual preferment; especially is this true at present in general medicine. Owing to the present disparity between their numbers and the consultant vacancies they have no assured future in the hospital service; at the same time they are virtually debarred from entry into general practice by the difficulty of such entry and by their age (thirty-five to forty or over being the usual age of appointment to a consultant post) and their specialised experience.

There is need for more consultants in the service, but expansion is hampered by the budgets of Regional Boards.

Registrars are at a financial disadvantage compared with the general practitioner, since their salary is considerably less than the average earnings of a general practitioner of the same age. In addition, they have no expenses allowance for membership of learned societies, for a car and other necessary expenses. They may be required to change their place of work at short notice, without any financial allowances for the heavy expenses incurred. In the case of senior registrars these moves are additionally inconvenient, since they are more likely to interfere with the schooling of children. It is not surprising, therefore, that it is becoming increasingly difficult to fill registrar posts, particularly in peripheral hospitals where the chances of promotion are less good.

A number of highly trained senior registrars, unable to obtain a consultant post, are emigrating. This is both wasteful in training and money; further, with over-long in-patient and out-patient waiting lists in some of our hospitals, there is an increasing need for such doctors, and their absence must prove in the end harmful to our National Health Service.

It is difficult to obtain reliable figures concerning emigration of men of registrar or senior registrar status, but the experience of one consultant neurologist is illuminating. In the last ten years nine senior registrars in neurology personally known to him have emigrated—six to Canada, two to the United States of America, and one to South Africa.

Incentives are needed if able men are to be attracted as registrars and senior registrars in training for the Consultant Service. Prior to the National Health Service, a great difference existed between the earnings of consultants and general practitioners. This resulted in attracting specially able recruits to consultant practice. They were willing to put up with certain early hardships, because the future rewards might be great. This differential has shrunk and indeed for younger consultants has been entirely reversed.

It is our conviction that the differential must be maintained as an element of recruitment. Otherwise the efficiency of the Hospital Service will deteriorate.

Q. (ix) The Difficulties of Entering General Practice, with Special Reference to the Position and Prospects, Financial and Otherwise, of Assistants

The College is not in a position to deal with this question in any detail, but feels that it should draw attention to the difficulties of entering general practice.

Before 1948 those with higher degrees were welcomed into general practice, but this is no longer so; indeed it is very hard for anyone who has worked in hospital for more than a year or two to enter general practice at all. In addition

the rigidity of the system makes it difficult if not impossible for general practitioners themselves to move once they have settled in practice. These problems should be investigated in the interests of the service and of the community. For instance, the possibility of some form of additional remuneration for general practitioners based on the possession of higher qualifications and experience as well as quality of service might be considered. Further, the desirability of general practitioners being associated with their local hospitals and holding paid appointments as clinical assistants in them, should be further explored.

Q. (x) The Importance of Private Consulting Practice as an Incentive to Entering the Consultant Branch of Medicine

Private practice is still an incentive for entering consultant practice. The financial rewards are becoming less, but many wish to enter private consulting practice because they are able to spend more time on individual patients under conditions of their own choosing, and the freedom to do this makes their work more satisfying. The opportunity to practice privately must be preserved, partly because there is some public demand for it and partly as a safeguard against complete State control, which would not be in the best interests of medicine.

Q. (xi) Expenses in General Practice, how Far they Vary above and below the Average and how far Payments, e.g., towards Capital, have to be made which are not Allowable as Expenses for Income Tax Purposes

The College regrets that it is not in a position to give any useful opinion on this matter.

Q. (xii) Comparative Treatment for Income Tax Purposes and in Relation to Expenses of Whole-Time and Part-Time Consultants in the National Health Service

The part-time consultant, if assessed wholly under Schedule D, has income tax relief for many items such as car purchase, travel, telephone and books, which are not allowed to the whole-time consultant although he may have equal need of them. This relief may also be disallowed to the part-time consultant if, as many now are, he is assessed under Schedule E in respect of his National Health Service earnings. An added difficulty may be experienced by such a consultant in his early days of private practice, when his earnings under Schedule D may be so small that his expenses cannot be covered.

Medicine is advancing with great rapidity, and lack of knowledge of new developments may be detrimental to patients. We consider that allowances should be granted to all doctors for what they spend on attending scientific meetings, whether reading papers or not, for subscription to learned societies, and for the purchase of medical books and journals, because these are essential for the maintenance of professional standards.

Q. (xiii) Any Anomalies in the Methods of Payments of any Branch of the Profession, e.g., Maldistribution as Opposed to a Wrong Total Volume

As previously stated, it is very important that financial incentives should not work towards depriving the consultant specialties of able men and women whom they must have if they are to maintain and raise their standards as in the past.

Another anomaly is the starting salary of consultants who are first appointed at more mature ages than 32 years. Such salaries are inadequate, and more use should be made of the discretion allowed to Regional Boards to start such newly appointed consultants at points higher on the salary scale than the lowest, which is designed for men starting at the age of 32.

Q. (xiv) Comments on the Present System of Calculating and Distributing General Practitioners' Remuneration through a Central Pool

The College does not wish to comment on this question.

Q. (xv) *General Comments on the System of Merit Awards and the Method of Allotting them, with any Suggestions for an Alternative System*

The College made reference to Distinction Awards in Part I of its evidence on page 13, and wishes here to add that in order to encourage the maintenance of a high standard of work throughout a consultants' working life, merit awards must be retained. The present method of allocation should not be changed. The 1954 abatement of salaries for those receiving A and B awards should be eliminated. The amount of the awards is still the same as that recommended in Spens report, *i.e.*, in terms of the value of money in 1939. No increases have been made. In order that the system of Distinction Awards shall continue to perform its important functions, they should now be increased by 60 per cent.

Q. (xvi) *Particulars of Financial Stringency Suffered by any Classes of Doctors Illustrated by Personal Budgets of Practitioners*

Members of the College have submitted personal budgets which we forward herewith as an Appendix. They cover the junior appointments in the hospital service up to and including that of senior registrar. They illustrate the financial difficulties which have to be met during training for consultant work.

Q. (xvii) *Special Considerations of which Account Ought to be Taken in Discussions of Medical Remuneration*

This question has already been dealt with in Part I of our evidence. We would like to repeat that in comparing remuneration of doctors with that of other professions the nature of their work should be taken into account.

First, the care of ill people is a burden of responsibility which is carried by practising doctors day and night throughout their professional life.

Secondly, their duties may involve compulsory residence in hospital, more particularly in their earlier years.

Thirdly, advances in medicine, great and rapid at the present time, throw an increasingly heavy responsibility on each doctor of keeping himself up to date. It is possible that this is a greater duty than exists in other professions.

Fourthly, the College considers that every doctor should feel a responsibility to contribute where he can to the advancement of medical knowledge and the improvement of treatment of the sick.

Q. (xviii) *Specific Proposals for Medical Remuneration*

The following scales are proposed. They are calculated on the basis of increases of between 29 per cent. and 30 per cent. on the basic salaries and 60 per cent. on distinction awards, and with removal of the abatement of the basic salary applied to consultants with A and B distinction awards in 1954.

Scales Recommended

Consultant with "A" Distinction Award	£6,709-£7,999.
Consultant with "B" Distinction Award	£5,109-£6,399.
Consultant with "C" Distinction Award	£3,509-£4,799.
Consultant on basic scale	£2,709-£3,999.
S.H.M.O.	£2,031 15s. £2,612 5s.
Senior Registrar	£1,419-£1,806.
Registrar	£1,096 10s.-£1,244 17s. 6d.
J.H.M.O.	£999 15s.-£1,386 15s.
Senior House Officer	£950.
House Officer	Pre-reg. £550. 2nd year-£650-£700.

Q. (xix) *The Practicability of the Profession Establishing a Fixed Scale of Payments for Assistants in General Practice*

The College regrets that it is not in a position to give any useful opinion on this question.

Q. (xx) Proposals for Specific Machinery or Procedure to be Established for Dealing with Future Discussions of Medical Remuneration

It is proposed that a Committee on similar lines to that recommended by the *Royal Commission on the Civil Service be established to keep the remuneration of doctors and dentists in the National Health Service continuously under review and advise the Government accordingly. Among its duties should be that of receiving representations from time to time from the professions.

Q. (xxi) Any Factors other than Remuneration which are Affecting the Contentment of General Practitioners

The College regrets that it is not in a position to give any useful opinion on this question.

APPENDIX

PERSONAL BUDGET OF

House physician (1st post)	Age: 25 years
Married	No children
	£ s. d.
Gross SALARY per month	37 15 0
Deductions (S/A, National Insurance, Income Tax, Residence) ...	13 8 0
Net Income	£24 7 0
EXPENDITURE	
	£ s. d.
House (rates, heating, etc.)	22 15 0
Telephone	1 2 6
Travel (to see wife)	3 4 0
Housekeeping	13 0 0
	£40 1 6
	£24 7 0

Wife has been fortunate in obtaining part-time jobs. Rent is expensive because it is impossible to obtain short-lease unfurnished accommodation within reasonable distance of the hospital.

PERSONAL BUDGET OF

House physician (2nd post)	Age: 25 years
Married	Wife expecting baby
	£ s. d.
Gross SALARY per month	41 17 6
Deductions (S/A, National Insurance, Income Tax, Residence) ...	14 6 0
Net Income	£27 11 6
EXPENDITURE	
	£ s. d.
House (rates, heating, etc.)	16 16 0
Telephone	1 5 0
Housekeeping	12 0 0
Miscellaneous (life insurance, clothes, etc.)	5 0 0
	£35 1 0
	£27 11 6

Car expense not included in expenditure.

Wife was working but has had to give up her job because of her pregnancy.

* Royal Commission on the Civil Service, 1953-55. Cmd. 9613.

PERSONAL BUDGET OF

Senior House Officer (resident)	...	...	...	...	...	Age: 27 years	
Married	...	...	...	...	...	1 child	
GROSS INCOME PER ANNUM	...	...	...	...	...	...	£ 819
Deductions (S/A, National Insurance, Income Tax, Residence)	...	...	...	...	...	...	270
Net Income	...	...	...	...	...	...	£549

EXPENDITURE

							£
House (rates, heating, etc.)	...	...	...	...	...	...	213
Telephone	...	...	...	...	...	...	12
Travel to work	...	...	...	...	...	...	—
Housekeeping (food, laundry, etc.)	...	...	...	...	...	...	208
Examination fees	...	...	...	...	...	...	21
Miscellaneous (life insurance, books, clothes, car, school fees, tobacco, etc.)	...	...	...	...	...	...	225
							£679
							£549

PERSONAL BUDGET OF

Registrar (non-resident)	...	...	...	...	...	Age: 32 years	
Married	...	...	...	...	...	2 children	
GROSS INCOME PER ANNUM	...	...	...	...	...	...	1,061
Deductions (S/A, Income Tax, National Insurance)	...	...	...	...	...	...	203
							£858
Additional child allowances	...	...	...	...	...	...	20
Net Income	...	...	...	...	...	...	£878

EXPENDITURE

							£
House (rates, heating, etc.)	...	...	...	...	...	...	258
Telephone	...	...	...	...	...	...	14
Travel to work	...	...	...	...	...	...	32
Housekeeping (food, laundry, etc.)	...	...	...	...	...	...	328
Examination fees	...	...	...	...	...	...	53
Miscellaneous (life insurance, school fees, books, clothes, etc.)	...	...	...	...	...	...	149
							£834
							£878

PARTICULARS OF

PERSONAL BUDGET FOR YEAR AUGUST, 1956, TO AUGUST, 1957 OF

Senior Registrar (2nd year appointment)	Age: 33 years
Married	1 child (aged 3 years)
	£
GROSS INCOME PER ANNUM	1,220
Deductions (Income Tax, Superannuation, National Insurance) ...	234
Net Income (plus £36 for Travelling Expenses)	£1,022
EXPENDITURE	
	£
House (rates, mortgage, heating, etc.)	312
Telephone	18
Travelling	93
Housekeeping	344
Miscellaneous (bank interest, newspapers, etc.)	184
	£951
	£1,022

From the balance of £71 items such as

- (a) Clothing and repairs,
- (b) Holidays,
- (c) Entertainment,
- (d) House maintenance repairs,
- (e) Personal expenses,

all have to be found.

Note.—Accommodation has always been difficult to obtain, and the only available places have been furnished flats at 4 to 4½ guineas a week, therefore the expenditure on the House is about the same as renting a flat. Initially the Bank lent me the £250 deposit for this, since this has been lent I have had to purchase a car. There is still £265 in the loan account.

ESTIMATED PERSONAL BUDGET FOR YEAR 1957-58 OF

Senior Registrar (5th year appointment)	Age: 32 years
Married	2 children (3 years: 6 months)
	£
GROSS INCOME PER ANNUM	1,540
Deductions (P.A.Y.E. and National Insurance, etc.)	370
Net Income	£1,170
EXPENDITURE	
	£
House (Building Society, rates, heating, repairs, insurance and furniture, etc.)	290
Telephone	15
Travelling (car, £120—hospital allowance £20)	100
Housekeeping	400
Miscellaneous (personal lunches, insurances, books, journals, clothing for family, gifts, holidays, entertainments)	285
	£1,090
	£1,170

No account is made for capital depreciation on the car or house and no allowance made for removal expenses liable at any time. (Average rate, £150 per annum).

In view of this unsound financial state and the school fees coming along in two years' time, it is necessary for my wife to do a part time Clinical Assistantship (4 sessions per week).

GENERAL PRACTICE REFORM ASSOCIATION

(Day 9)

SUPPLEMENTARY MEMORANDUM OF EVIDENCE

The Executive Committee of the General Practice Reform Association, having studied the Minutes of Evidence on the examination of its representatives on 20th February, 1958, is conscious that the answers given to some of the questions put by the Commissioners may not have been sufficiently detailed to explain fully the standpoint of this Association. We would therefore like to ask the indulgence of the Royal Commission to accept and consider this Supplementary Memorandum, which consists of amplifications on these points.

ASSISTANTS' REMUNERATION

Paragraphs 2197-8, re Wages Council for Assistant General Practitioners (or equivalent machinery under the Ministry of Health)

In addition to the frequent problems of poor prospects and insufficient remuneration, assistants are often required to work with grossly inadequate off-duty time; in terms of remuneration, this can be expressed as an inadequate rate of remuneration for hours on duty. This rate may be so low as to amount to exploitation such as perhaps no longer exists for any other group of employees in this country.

In our view the assistant's rate of remuneration is meaningless unless expressed in terms of hours of work per week or fortnight. Even if satisfactory arrangements could be made within the profession for minimum net salaries to be paid to assistants, we cannot see how such arrangements could safeguard adequate rates of pay in relation to hours of work. A satisfactory minimum rate of remuneration for assistants necessarily involves a limited amount of ordinary on-duty time; a minimum amount of off-duty time; and extra remuneration for "overtime". In our opinion, the normal amount of on-duty time should be 5 working days per week from the beginning of the morning surgery to the end of the evening surgery, plus half a day per week from the beginning of the morning surgery to 1 p.m. The minimum amount of off-duty should be alternate nights (after the end of evening surgery), alternate week-ends, one half-day per week, statutory holidays or other days in lieu, and four weeks' paid holiday per year.

We consider that these conditions of employment could be enforced only by a Wages Council or by alternative machinery under the Ministry of Health. The just grievances of present and future assistants will not be satisfied until suitable minimum standards of off-duty are enforced, and it is for this reason that any abstract desire in the profession for this matter to be settled completely inside itself should be disregarded.

We should like again to draw attention to the persistent but frustrated efforts which have been made in the past by this Association to secure for assistants satisfactory conditions of work negotiated through the profession's channels. (These were described in Section IV of our first memorandum of written evidence on assistants' remuneration.)

The "Emergency Call Services": The phenomenal growth in recent years of the business hiring of deputy doctors has led to a new class of employed doctor being paid on a sessional basis and often underpaid and exploited, and these also require minimum standards of remuneration to be laid down. Incidentally, the easy availability of the medical man-power for these businesses reflects the surplus of unestablished doctors unable to find better employment.

Examples

We append below a few further examples, quoted from letters we have received from assistants, to illustrate the long hours of on-call duty that assistants are frequently required to work.

(1) "Eventually I was offered an assistantship definitely without view in a practice in the East End of London where the two principals were of eastern

pace and one had a son soon to qualify. I was to have £700 per annum and to live in two rooms above the surgery in a slum, two other rooms in the premises being occupied by one of the principals, who seemed content with incredible squalor. . . . I did all the morning visits and finished the round, no matter what time it kept me. Four days a week I was on all day for all late calls, and these four days included Saturday and Sunday, which I never had off until I had been in the practice 4½ years . . . following the 5 per cent. increase I asked for another increase (salary at the time £850) but was told this was impossible as expenses had gone up so much."

(2) "In February, 1954, I was engaged as assistant by a doctor in an East of Scotland county town. I knew that the pay was poor and that his assistants were not well treated, but as I was on the dole I had no real alternative. This was a semi-rural practice of 2,000 N.H.S. and several hundred private patients, the latter being seen by the principal, by appointment. For N.H.S. patients there were 15 surgeries weekly, of which I conducted 11; for the N.H.S. side of the practice I did 95 per cent. of new calls, all evening calls and all night calls. My time off was from after morning surgery till midnight, two days a week. . . . My salary was £800 per annum less £150 for accommodation. The principal was recognised as a trainer, and had only taken me on as an ordinary assistant when he was unable to get a trainee; after nine months I was given notice because he had managed to get one. . . . He has now taken his son into partnership. . . . After another three months doing locums I was again on the dole when I was offered and accepted a job, again without view, in a practice of 3,500 in a small industrial town in central Scotland. . . . Conditions here were better; I was treated as a colleague, and up to 7 p.m. the work was fairly evenly divided. Most of the evening work, however, and all the night work was done by me. There was a rota in operation which gave ample time off, but when it was the turn of our practice it was invariably I who was on call; I even used to arrange a swap with some other practice when I went on holiday so that the principal would not have to do any rota duty when I was away."

(3) "I have been an assistant to the senior of two partners since April, 1957, and apart from one half-day per week and alternate week-ends (noon Saturday to midnight Sunday) I have been on permanent call for my employer's patients. His partner has been with him for 12 years and will never reach parity—the senior man having a 5 per cent. bonus—and he, like me, has alternate week-ends, one half-day per week and is on permanent call for his patients. My employer holds M.O.H., Executive Council and other posts, will not agree to the assistant being shared by himself and partner, and has in four years employed four assistants. I need hardly add that the senior partner can take every week-end off and as many half-days as he chooses. He does 45 minutes in morning surgery from Monday to Saturday, and the same length of time in evening surgery on Tuesday and Friday, the surgery being continued after that time by the assistant. The two partners are entitled to 31 days holiday each per year, the assistant to 21 days; and if reserve training involves any loss of time from the practice the assistant forfeits this out of his 21 days. Otherwise the assistant takes his holiday at the same time as the senior partner for two reasons—there can thus be no time when the assistant can be away and leave his employer to take calls; and the junior partner is thus left on his own to cope with the double practice for at least three weeks, during which time he must pay for a locum out of his own pocket or do all the work himself."

(4) ". . . at present I get only alternate Sundays away from the practice to which I am an assistant and otherwise am tied to the telephone. I find this is barely enough time in which to have any relaxation . . ."

THE ASSISTANTSHIP SYSTEM

Paragraph 2204, re the Extra List of Patients

We do not regard the private employment of one doctor by another as conducive to good professional relationship; particularly is it inappropriate, to say the least, in a publicly organised health service. If it is wrong to buy and sell patients (the argument put forward for the abolition of the sale and purchase of

goodwill when the N.H.S. was introduced), it is surely equally wrong to subvert them.

We wish to stress that in our opinion there are only two justifiable reasons for the employment of an assistant: (a) as a means of training for general practice, and (b) as an introduction to partnership. We view with abhorrence the official attitude of the profession as stated by a sub-committee of the G.M.S.C. that "there is nothing improper or unethical in a principal enjoying a monetary reward in respect of the indefinite employment of an assistant". It would not be too much to say that we regard the present position of the employment of assistants in the N.H.S. as a national scandal.

The factor which, more than any other, makes the exploitation of unestablished doctors possible, and which constitutes the substance of our complaint against the assistantship system, is the permanent extra list of up to 2,000 patients for employing an assistant. We maintain that an extra list should only be permitted in order to allow a principal who genuinely desires to take a partner to bridge the gap between having too much work for one and not enough income for two on the one hand, and having work and money for two on the other. Our view is that an extra list should only be allowed for a limited time (up to 2 years) and where a view to partnership is genuinely intended and intimated to the Executive Council. This would be a strong stimulus to the formation of new partnerships.

In this connection we should like to draw the Royal Commission's attention to the fact that one Executive Council in England has informed us that it limits the permission to a principal to employ an assistant to a period of 12 months, and it has found that this policy has had a marked effect in inducing principals to take their assistants into partnership; the policy receives the whole-hearted support of the Council's Local Medical Committee. It is a pity that other Executive Councils have not followed this example.

Our objections to the present working of the assistantship system, based as it is upon an unlimited duration to the possession of an extra list of a maximum size of 2,000 patients are:—

1. *Principal's income structure*: The higher reward in general practice from the N.H.S. is not by merit (quality of service) nor even by number of patients actually attended (quantity of service), but by being in a position to employ an assistant at a real cost much less than the income that is thereby obtainable from the N.H.S.

2. *Public policy*: This provision in the N.H.S. for sub-contracting at lower cost seems to us to involve an abuse of public money.

3. *Entry into practice as a partner*: There is a financial disincentive in many instances for an assistantship "without a view" to become one "with a view".

4. *Standards of practice*: We believe that the divorce between actual work performed and maximal financial reward from the N.H.S., and the encouragement of assistantships without a view with which this is associated, both have an adverse influence on standards of practice.

REMUNERATION OF PRINCIPALS

Paragraphs 2274, 2280-2, 2293 4, re Methods of Rewarding Merit

We wish to emphasise once more that we disagree with the B.M.A.'s view, expressed in their evidence to the Royal Commission, that the ability to attract a large number of patients is a measure of a G.P.'s professional ability.

The Ministry of Health recently, in replying to a petition from a doctor's patients (which had complained against his being fined for over-prescribing and stated that he had effected remarkable cures) commented that the patient was not necessarily the best judge in assessing a doctor's clinical ability. With this view we would agree. In fact, to reward doctors solely on a basis of the number of patients registered with them tends, in our opinion, to put a premium on hasty and inadequate work, since the more patients a doctor has, the less time he has to devote to each.

It is obvious that the size of a practice at any given time depends upon a number of factors which are quite independent of the individual practitioner's qualities, whether good or bad; these include, for example: the length of time that the practice has existed; the area of the practice and density of population; the amount of local opposition; the site of the surgery and its accessibility. Thus, in a town, all the large practices are invariably long-established, with surgeries on main roads with easy access to public transport, irrespective of the personal qualities of the doctors. To argue that a doctor taken into a large partnership, or appointed to a long-established practice vacancy is *qualitatively* better than a "squatter" in a side street *because* he has a larger list is quite nonsensical.

The Spens Report recommended giving more remuneration to doctors with more merit. However, in practice, the method of G.P. remuneration in the N.H.S. has worked out so as to give more money to those doctors with more patients, and the B.M.A. has unconsciously (and fallaciously) accepted the principle that more patients must therefore necessarily imply more merit.

Naturally, in assessing the amount of money that ought to be paid to general practitioners, account must be taken of the quantity of work undertaken by the doctor up to a point, that point being the maximum number of patients for whom it is considered that the proper standard of medical care can be provided (2,000 in the G.P.R.A. view), subject to national economic considerations. But we do not think it right that this is the only factor that should be taken into account—hence our proposal to reward greater experience by means of length of service increments.

In our oral evidence we tried to make it clear that the G.P.R.A. would not be opposed to additional measures, over and above our basic proposals, designed to recognise merit in a G.P., if a suitable scheme could be devised. We should like to mention here that it may be possible to devise such a scheme, by taking into account a number of factors such as, for example, higher qualifications, publication of original work, being on the Obstetric List, taking of regular refresher courses, though no single one of these by itself is necessarily proof of higher professional ability. (Cf. the article, "Merit Awards for General Practitioners" by J. F. Burdon, M.B., B.S., D.A., British Medical Journal Supplement, 12th July, 1958, p. 27.)

We should like in passing to draw attention to the fact that a system for rewarding merit on account of such achievements already exists, viz., the trainee general practitioner scheme, whereby the trainer principal is selected on the basis of his suitability as a trainer—no doubt taking into account such considerations as the above—and receives in return a training grant of £150 and the services of an assistant at State expense. In practice, the employment of a permanent assistant often works in much the same way, without any suggestion of merit being made, but solely by virtue of the extra list.

NUMBER OF PATIENTS PER PRACTITIONER

Paragraph 2330, re Proposed Maximum of 2,000 N.H.S. Patients per Practitioner

In addition to the pointers from various sources towards a figure of 2,000, given in our written evidence on pages 427-8, we would add that the Darbishire House Health Centre has reported that it might well be that 2,000 patients is the optimum number per doctor. (Supplement to British Medical Journal, 18th January, 1958.)

Paragraph 2380, re Effect of too many Patients on Mode of Practice

Too many patients cause the doctor to get through his work at an unnatural pace. Sir Francis Fraser has commented: "It is disturbing to hear so often from members of the public, 'I didn't tell the doctor about that, he seemed too busy', or, 'I told the doctor, but he paid no attention to that'." (The Lancet, 18th January, 1958.) An adequate reduction in the number of patients cuts out this "pressure of time" factor, and so the relevant points in the patient's history are brought so light; they can no longer be hidden or ignored, and consequently have to be dealt with. Thus in our view, some improvement in standards would be inevitable if maximum list sizes were reduced to medically manageable levels.

Reasons for Irrelevancy of Spens (1)

9. The Association have considered most carefully the matter of the first Spens dental recommendation, and hold to the opinion expressed in paragraph 65 of their main memorandum that "for all practical purposes this particular Spens recommendation has no relevancy." It is submitted that a careful reading of paragraphs 17 and 18 of the Spens Dental Report will indicate that the Spens Committee themselves had grave doubts as to whether the circumstances that existed in 1938, and which gave rise to the spread of dental incomes at that time, would ever exist again, hence their statement in paragraph 18 that "action should be based on this figure (£1,600)." Amongst the many factors that gave rise to the 1938 spread of incomes, the Spens Committee mention three, all of which have now changed entirely. The first change of circumstances from 1938 conditions mentioned in paragraph 17 of the Report is the removal of the economic barrier to dentistry. It cannot be denied that the introduction of a free dental service resulted in a very great increase in the demand for dentistry, and although the introduction of charges temporarily reduced the demand rate, it still remained very high in comparison to the demand that existed in 1938. The Association freely admit that by raising or varying the charges for dentistry, the Government of the day can alter this demand rate. But any Government that decided to introduce high charges for dentistry in the Health Service would have to face the possibility of grave political repercussions, and in any event, unless dentistry was entirely removed from the benefits that the public can obtain within the Health Service, the demand rate would be most unlikely to fall to the 1938 level.

10. The second "uncertainty" as regards the effect on the 1938 demand rate which is mentioned by the Spens Committee in paragraph 17 is in respect of the education of the public to take greater care of their teeth. The Association are only too aware of the need for educating the public in matters of dental health, and welcome the recent setting up by the Ministry of Health of the Standing Committee on Dental Health Education, and the impending appointment of its Scottish counterpart. At the same time, as indicated in recent Ministry of Health Reports, and mentioned in paragraph 11 of the Association's main memorandum, there is definite evidence that more and more of the population are seeking conservative treatment, and are returning to their dentists at regular intervals. The position in this respect has improved very much in the last twenty years, and particularly since the start of the Health Service, and again the Association cannot visualise this increased public interest in dental health evaporating overnight and returning to the 1938 level, even in the unhappy event of charges being increased or their scope being widened.

11. There can be no argument about the third factor which is mentioned in paragraph 20 of the Spens Report as contributing towards the spread of incomes in 1938. This is the variation in fees charged by dentists prior to the Health Service. While there is in operation a standard scale of fees system, this factor which helped to secure differentiation in incomes in 1938 has been entirely removed as regards dentists in the Health Service.

12. Two further points arise in considering the first Spens dental recommendation. The Commission are well aware of the contents of the McNair Report and of the shortage of dental man-power, which is dealt with fully in Part V of the Association's main memorandum. The Association are sure that the Commission will accept the fact that it is quite impossible to reproduce the condition of under-employment in the profession which would be necessary to achieve the 1938 spread of incomes by the apparently simple expedient of suddenly producing a large number of extra dentists.

13. The second point arises in connexion with the method of remuneration. Spens recommendation No. 3 is quite definite that if remuneration is to be by a scale of fees, then it must be a "balanced" scale. The method of calculating a "balanced" scale of fees is fully explained in paragraph 101 of the Association's main memorandum, and two essential factors in the calculations are a target figure for the dentist to earn and the number of chairside hours that he must work to earn that figure. Spens recommendation No. 1 contains

no target figure for the profession in general, since it relates only to one age group, nor as pointed out above, are any particular number of chairside hours associated with any particular income group. It would, therefore, be quite impossible to implement Spens recommendation No. 1 by means of a "balanced" scale of fees.

14. The Association therefore submit that the changes in circumstances visualised by the Spens Committee have in fact taken place, that there can be no spread of incomes comparable with that in 1938, and therefore that the Spens Dental Recommendation No. 1 has in the words of the Spens Report "little or no relevance to the actual circumstances."

Spens Dental and Medical Recommendations Compared

15. It remains to deal with the question of the relationship, if any, between the recommendations of the Spens Medical and Dental Committees. In the first place, it must be said that from the Minutes of Evidence presented to the Royal Commission by the British Medical Association (page 258, para. 1140) it would appear doubtful whether the first and main recommendation of the Spens Medical Committee, which in wording is somewhat similar to Spens Dental Recommendation No. 1, has ever been implemented in detail. It is equally doubtful whether such likeness as may exist between the two recommendations in question extends beyond the wording, and in any event the first dental recommendation has already been shown to be completely irrelevant in present and likely future circumstances. The fact is that proper comparison between medical and dental incomes, both target and actual, could only be made if the circumstances and duration of employment were comparable, i.e. if all doctors had the maximum permitted numbers of patients on their lists, which would presumably constitute full employment, and all dentists were able to restrict their working hours to the Spens figure of 1,500 per year.

PART IV

THE INLAND REVENUE INQUIRY

Royal Commission's Own Inquiry Results Still Awaited

16. The opportunity is taken to comment on the figures produced by the Inland Revenue Inquiry into incomes and expenses of National Health Service general dental practitioners in Great Britain during the year 1955-56. The observations which follow are necessarily made in advance of publication and examination of the results of the Commission's own inquiry which, however, will embrace not only practitioners in all spheres of dentistry but also members of other professions.

Figures Lower than Envisaged in Main Memorandum

17. The Inland Revenue results show that in their estimate of the gross earnings of single-handed practitioners in 1955-56 (first Memorandum, paragraph 82) the Association were unduly optimistic: the estimated figure was £3,480 but the actual figure shown by the inquiry is only £3,272. The average net income figure emerging from the reconciliation of gross incomes and expenses in the case of single-handed dentists is only £1,641, as compared with an estimate of £1,812 in the first Memorandum.

Improvement in 1952-53 position only by virtue of abolition of 10 per cent. Cut

18. The situation indicated by the above figure of £1,641 is that had it not been for the abolition of the 10 per cent. cut in gross fees the net financial position of single-handed practitioners in 1955-56 would have been no better than in 1952-53, when the single-handed average was £1,345 net. Bearing in mind the 10 per cent. restoration it is obvious that expenses must have risen very considerably during the intervening three-year period: indeed direct comparison can be made between the two sets of inquiry figures if for the purpose of calculation it is assumed that the 10 per cent. cut was not operative in 1952-53. Had that been the case the 1952-53 expense ratio for all practitioners would have been 48 per cent. as against 52 per cent. in 1955-56 and the ratio for single-handed practitioners would likewise have been 48 per cent. against

Reasons for Irrelevancy of Spens (1)

9. The Association have considered most carefully the matter of the first Spens dental recommendation, and hold to the opinion expressed in paragraph 65 of their main memorandum that "for all practical purposes this particular Spens recommendation has no relevancy." It is submitted that a careful reading of paragraphs 17 and 18 of the Spens Dental Report will indicate that the Spens Committee themselves had grave doubts as to whether the circumstances that existed in 1938, and which gave rise to the spread of dental incomes at that time, would ever exist again, hence their statement in paragraph 18 that "action should be based on this figure (£1,600)." Amongst the many factors that gave rise to the 1938 spread of incomes, the Spens Committee mention three, all of which have now changed entirely. The first change of circumstances from 1938 conditions mentioned in paragraph 17 of the Report is the removal of the economic barrier to dentistry. It cannot be denied that the introduction of a free dental service resulted in a very great increase in the demand for dentistry, and although the introduction of charges temporarily reduced the demand rate, it still remained very high in comparison to the demand that existed in 1938. The Association freely admit that by raising or varying the charges for dentistry, the Government of the day can alter this demand rate. But any Government that decided to introduce high charges for dentistry in the Health Service would have to face the possibility of grave political repercussions, and in any event, unless dentistry was entirely removed from the benefits that the public can obtain within the Health Service, the demand rate would be most unlikely to fall to the 1938 level.

10. The second "uncertainty" as regards the effect on the 1938 demand rate which is mentioned by the Spens Committee in paragraph 17 is in respect of the education of the public to take greater care of their teeth. The Association are only too aware of the need for educating the public in matters of dental health, and welcome the recent setting up by the Ministry of Health of the Standing Committee on Dental Health Education, and the impending appointment of its Scottish counterpart. At the same time, as indicated in recent Ministry of Health Reports, and mentioned in paragraph 11 of the Association's main memorandum, there is definite evidence that more and more of the population are seeking conservative treatment, and are returning to their dentists at regular intervals. The position in this respect has improved very much in the last twenty years, and particularly since the start of the Health Service, and again the Association cannot visualise this increased public interest in dental health evaporating overnight and returning to the 1938 level, even in the unhappy event of charges being increased or their scope being widened.

11. There can be no argument about the third factor which is mentioned in paragraph 20 of the Spens Report as contributing towards the spread of incomes in 1938. This is the variation in fees charged by dentists prior to the Health Service. While there is in operation a standard scale of fees system, this factor which helped to secure differentiation in incomes in 1938 has been entirely removed as regards dentists in the Health Service.

12. Two further points arise in considering the first Spens dental recommendation. The Commission are well aware of the contents of the McNair Report and of the shortage of dental man-power, which is dealt with fully in Part V of the Association's main memorandum. The Association are sure that the Commission will accept the fact that it is quite impossible to reproduce the condition of under-employment in the profession which would be necessary to achieve the 1938 spread of incomes by the apparently simple expedient of suddenly producing a large number of extra dentists.

13. The second point arises in connexion with the method of remuneration. Spens recommendation No. 3 is quite definite that if remuneration is to be by a scale of fees, then it must be a "balanced" scale. The method of calculating a "balanced" scale of fees is fully explained in paragraph 101 of the Association's main memorandum, and two essential factors in the calculations are a target figure for the dentist to earn and the number of chairside hours that he must work to earn that figure. Spens recommendation No. 1 contains

no target figure for the profession in general, since it relates only to one age group, nor as pointed out above, are any particular number of chairside hours associated with any particular income group. It would, therefore, be quite impossible to implement Spens recommendation No. 1 by means of a "balanced" scale of fees.

14. The Association therefore submit that the changes in circumstances visualised by the Spens Committee have in fact taken place, that there can be no spread of incomes comparable with that in 1938, and therefore that the Spens Dental Recommendation No. 1 has in the words of the Spens Report "little or no relevance to the actual circumstances."

Spens Dental and Medical Recommendations Compared

15. It remains to deal with the question of the relationship, if any, between the recommendations of the Spens Medical and Dental Committees. In the first place, it must be said that from the Minutes of Evidence presented to the Royal Commission by the British Medical Association (page 258, para. 1140) it would appear doubtful whether the first and main recommendation of the Spens Medical Committee, which in wording is somewhat similar to Spens Dental Recommendation No. 1, has ever been implemented in detail. It is equally doubtful whether such likeness as may exist between the two recommendations in question extends beyond the wording, and in any event the first dental recommendation has already been shown to be completely irrelevant in present and likely future circumstances. The fact is that proper comparison between medical and dental incomes, both target and actual, could only be made if the circumstances and duration of employment were comparable, i.e. if all doctors had the maximum permitted numbers of patients on their lists, which would presumably constitute full employment, and all dentists were able to restrict their working hours to the Spens figure of 1,500 per year.

PART IV

THE INLAND REVENUE INQUIRY

Royal Commission's Own Inquiry Results Still Awaited

16. The opportunity is taken to comment on the figures produced by the Inland Revenue Inquiry into incomes and expenses of National Health Service general dental practitioners in Great Britain during the year 1955-56. The observations which follow are necessarily made in advance of publication and examination of the results of the Commission's own inquiry which, however, will embrace not only practitioners in all spheres of dentistry but also members of other professions.

Figures Lower than Envisaged in Main Memorandum

17. The Inland Revenue results show that in their estimate of the gross earnings of single-handed practitioners in 1955-56 (first Memorandum, paragraph 82) the Association were unduly optimistic: the estimated figure was £3,480 but the actual figure shown by the inquiry is only £3,272. The average net income figure emerging from the reconciliation of gross incomes and expenses in the case of single-handed dentists is only £1,641, as compared with an estimate of £1,812 in the first Memorandum.

Improvement in 1952-53 position only by virtue of abolition of 10 per cent. Cut

18. The situation indicated by the above figure of £1,641 is that had it not been for the abolition of the 10 per cent. cut in gross fees the net financial position of single-handed practitioners in 1955-56 would have been no better than in 1952-53, when the single-handed average was £1,345 net. Bearing in mind the 10 per cent. restoration it is obvious that expenses must have risen very considerably during the intervening three-year period: indeed direct comparison can be made between the two sets of inquiry figures if for the purpose of calculation it is assumed that the 10 per cent. cut was not operative in 1952-53. Had that been the case the 1952-53 expense ratio for all practitioners would have been 48 per cent. as against 52 per cent. in 1955-56 and the ratio for single-handed practitioners would likewise have been 48 per cent. against

the 1955-56 ratio of 50 per cent. In considering the remarkable feature that but for the restoration of the 10 per cent. the average single-handed dental practitioner would have been no better off financially in 1955-56 than in 1952-53, it must also be remembered that a greater volume of work was performed in 1955-56, without which it is reasonable to suppose that there would have been a relative deterioration in the position.

19. The earnings of practitioners in all categories show a greater increase than those of single-handed practitioners alone, but even so the average net income figure revealed by the inquiry results is only £1,994. That figure cannot be regarded as satisfactory seeing that the Spens Dental Committee visualised in 1948 that practitioners employing assistants or working in partnership, or able to work more than the Spens hours, could and should achieve higher earnings than those advocated in Spens recommendation No. 2. In 1948 £1,994, although like the single-handed figure of £1,641 an average and not a basic figure, might have compared reasonably with the 1948 single-handed basic scale figure of £1,778. In 1958, however, both the single-handed figure and the all categories figure are completely unrealistic, even if judged in the light of the cost of living issue alone, and that, as the Commission are aware, is by no means the essence of the Association's case.

Likely Position in 1958

20. It may be thought that the position in 1958 is different from that in 1956 because still more work is now being performed and the interim increase of 2.6 per cent. in gross fees has been operative since May 1957. It must be realised, however, that since 1956 practitioners have had to meet increases in staff wages, in charges for electricity, gas, solid fuel, etc., in rates resulting from increased assessments, and in many cases in rents, so that it is questionable whether in 1958 the net financial position of practitioners is better than in 1956.

PART V

NUMBERS OF PATIENTS SEEN EACH DAY

Removal of Apparent Misconception

21. Paragraph 3750 of the Minutes of Evidence presented to the Royal Commission by H.M. Treasury, Ministry of Health and Department of Health for Scotland, gives the impression that the Commission were under the belief that the average number of patients seen each day by a general dental practitioner in the National Health Service is three. It may be that in fact there is no misunderstanding as to the true position but should there be it would certainly be contrary to the interests of the profession and it is therefore thought desirable to remove any possibility of misconception.

22. All that the figures quoted in paragraph 3750 show is that on average each dentist completes a course of treatment for three cases (i.e. patients) a day. The significant point is that for each case there is a course of treatment which extends over several visits. It is difficult to say what is the average number of these visits and the true situation is probably best revealed by the appointments book of an average dentist which will be found to contain each day a full list of appointments, at intervals probably averaging between 20 to 30 minutes, during the whole of his working time. To whatever may be the daily total of "booked appointments" must be added the emergency patients with whom most dentists have to deal in the course of a day, and even an emergency case may not be completed in one visit.

PART VI

REMUNERATION OF LOCAL AUTHORITY DENTAL OFFICERS

Developments Since First Memorandum Published

23. Part IX of the Association's first memorandum dealt with the remuneration of local authority dental officers and the present object is to bring the Royal Commission up to date with regard to developments in this particular connexion, since the submission of the first memorandum. The developments in question

have been adverse so far as the dental officers are concerned, inasmuch as a claim for improvement in their remuneration to bring them into line with the rest of the profession was rejected by the Management Side of the Dental Whitley Council.

The View of the Guillebaud Committee

24. In view of this regrettable development the Association think it appropriate again to draw the attention of the Royal Commission to paragraph 538 of the Report of the Guillebaud Committee, which is quoted in paragraph 123 of the first Memorandum and to reiterate that "local authority dental officers should be remunerated on the basis that they are dentists, with all the implications attendant upon engagement in the profession of dentistry."

Memorandum by Local Authority Associations

25. The Association are also aware that there has been submitted to the Royal Commission a Joint Memorandum from the Local Authorities Associations. In the B.D.A. Memorandum the section devoted to Local Authority dental officers was deliberately curtailed in length because it was known that despite representations made to the Government, the remit of the Commission precluded them from making recommendations with regard to the remuneration of Local Authority dentists although it would seem to be within their power to take into consideration the present position in that field of dental employment and possibly to comment thereon. In the circumstances, if the Commission propose to give detailed consideration to the memorandum produced by the Local Authorities Associations, the British Dental Association would welcome the opportunity in further verbal evidence of elaborating on the case for local authority dentists as outlined in their first memorandum.

PART VII

MEANS OF SETTLING DISPUTES WITH REGARD TO DENTAL REMUNERATION

Original Proposal for Arbitration

26. In their first memorandum the Association urged that there should be appointed an independent arbitrator, acceptable to the profession, who with the aid of two assessors would officiate in any disputes between the Government and the British Dental Association.

B.M.A. Scheme—on Lines of Coleraine Committee

27. The Association have now looked at the matter again in the light of points raised when verbal evidence was presented to the Commission by the Association themselves and by Government Departments. The Association have also been privileged to see the Supplementary Memorandum presented by the British Medical Association in which the proposal is advanced that there should be created a standing committee appointed by the Prime Minister which should be empowered to conduct an annual review of medical remuneration. The proposed committee, it is appreciated, would be comparable in some respects with the Coleraine Committee which is responsible for reviewing the remuneration of higher Civil Servants.

Standing Committee Acceptable to Dental Profession, provided Powers Sufficiently Wide

28. After careful consideration the Association have come to the conclusion that the interests of the dental profession could be safeguarded satisfactorily by the setting up of a standing committee very much on the lines of that proposed by the British Medical Association but with one major difference in so far as the remit of the committee is concerned. As the Association see it the task of an Advisory Committee in the case of the medical profession would be to review the remuneration of Health Service doctors, effect being subsequently given to the Committee's recommendations by variations in the size of the Central Pool for general medical practitioners and in the salaries of other doctors. A comparable committee in the

dental case, however, having pronounced their findings on the net remuneration of dental practitioners should have the additional responsibility, in the event of a dispute arising between the profession and the Health Departments on the formulation of a scale of gross fees designed to produce the advocated net remuneration, of advising the Chancellor of the Exchequer as to whether in their opinion the proposed scale would or would not implement their findings.

Copy of letter to the Royal Commission from the Secretary of the British Dental Association Remuneration of Dental Teaching Staff

In neither of the two memoranda submitted to the Royal Commission by the British Dental Association has reference been made to the position of University Dental Teaching Staff. This was because we were under the impression that the Royal Commission would not be directly concerned with the remuneration of the particular members of the dental profession. It has come to our notice, however, that the British Medical Association have, in their preliminary (Days 5-6, page 234) and third supplementary (Day 23, page 1270) memoranda of evidence, made certain observations regarding University whole-time Medical Teaching Staff and Research Workers. I have been instructed, therefore, to make it clear to the Royal Commission that the statement of case in the interests of Medical Teachers is equally applicable to Dental Teachers, and that the British Dental Association wish to be associated with the views expressed by the British Medical Association, in relation of course to the remuneration of University Dental Teaching Staff.

MEDICAL SUPERINTENDENTS' SOCIETY

(Day 20)

SUPPLEMENTARY MEMORANDUM OF EVIDENCE

1. Number of Medical Superintendents and Deputies in England and Wales

Figures were obtained from the Ministry in March, 1959, as follows:—

(a) Medical Superintendents

Type of Hospital	Consultants	S.H.M.O.s	Totals
Mental and Mental Deficiency ...	156	3	159
Diseases of Chest	53	10	63
Infectious Diseases... ..	18	4	22
Geriatric	1	5	6
General	55	10	65
Total number of Clinical Medical Superintendents			315

In addition 5 medical superintendents have no clinical grading. The Ministry reports that there are 331 medical superintendents. This leaves a discrepancy of 11, of whose clinical grading we have no knowledge.

However, this figure of 331 corrects very decidedly the total of 129 which was given in Appendix C of the Bradbeer Committee Report.

These Medical Superintendents who are graded as clinicians are designated in a variety of titles—medical director, physician superintendent, surgeon superintendent being the commonest. Many of these were obviously excluded from the Bradbeer figures.

(b) Deputy Medical Superintendents

102 Consultants and 50 S.H.M.O.s., making a total of 152. It is regretted that the type of hospital in which these deputies serve is not known. They are chiefly in mental and mental deficiency, infectious disease hospitals, and sanatoria. There are no purely administrative deputies, all being primarily clinicians.

2. Addendum to Paragraph 20 of our Memorandum

In this paragraph 20 we argued that "a medical superintendent should be given extra remuneration over and above his purely clinical colleagues". The Society has given much thought as to how such extra remuneration should be determined, if this proposition were supported by the Royal Commission. It was finally considered that the most suitable method would be to determine it on a percentage basis, e.g. 15 per cent. of the basic consultant or S.H.M.O. rate (i.e. excluding any merit award) for a medical superintendent, and 10 per cent. for a deputy.

3. We are aware that the Council of the British Medical Association have submitted to the Royal Commission a document adversely criticising certain paragraphs of the memorandum of evidence submitted by the Medical Superintendents' Society. While regretting this action of the B.M.A. against a minority group, the Society is quite content that its case should be judged on the evidence both written and oral already submitted.

Royal Commission on Doctors' and Dentists' Remuneration

WRITTEN EVIDENCE VOLUME 1

*Factual Memorandum
by the
Ministry of Health
and the
Department of Health for Scotland*

LONDON
HER MAJESTY'S STATIONERY OFFICE
1957

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INTRODUCTION

1. This memorandum contains information about the number, remuneration and conditions of service of medical and dental practitioners engaged in the provision of Hospital and Specialist Services, of General Medical Services, of Supplementary Ophthalmic Services and of General Dental Services in the National Health Service.

2. Part I of the memorandum relates to recruitment to the medical and dental professions in general, Part II to employment in the Hospital and Specialist Services, Part III to employment in the General Medical Services and the Supplementary Ophthalmic Services; Part IV to employment in the General Dental Services; and Part V to the National Health Service Superannuation Scheme in relation to doctors and dentists. Part VI contains information about the remuneration and general conditions of service of hospital administrators, nurses and other kinds of hospital officers who may be considered to come within the description of people engaged in the "connected occupations" mentioned in the Royal Commission's terms of reference.

3. The information given relates to the whole of Great Britain except where otherwise indicated.

PART I: RECRUITMENT

The Medical Profession

4. The number of doctors who qualify and enter practice each year depends on the output from the medical schools, which in turn is to all intents and purposes determined five or six years before by the number of students entering them. The whole question of the future number of doctors and medical students is at present being examined by a Committee under the chairmanship of the Rt. Hon. Henry Willink, which was set up in 1955 by the Minister of Health and the Secretary of State for Scotland with the following terms of reference:—

"To estimate, on a long-term basis and with due regard to all relevant considerations, the number of medical practitioners likely to be engaged in all branches of the profession in the future, and the consequential intake of medical students required."

The Committee's report is expected to be submitted to Ministers during the Summer.

The Dental Profession

5. Recruitment has recently been studied by the Interdepartmental Committee on Recruitment to the Dental Profession, under the Chairmanship of Lord McNair*. This Committee ascertained that, on the assumption that adequate facilities existed for the training of students in the pre-clinical year, the existing dental schools in Great Britain could accept annually a maximum of 645 students into the first year of the clinical course. This capacity of the schools to train students virtually sets an upper limit on the recruitment of dentists to the profession. Not all the schools are at present able to provide places for students up to the maximum number they had notified to the McNair Committee and a total of 595 places was estimated to be actually available at the beginning of the present academic year (1956-57) and the

* Report of the Committee on Recruitment to the Dental Profession (Cmd. 9861).

total number of students attending the first year of the course in January, 1957 was 582.

6. The McNair Committee recommended that the present training facilities should be extended, by expansion of existing dental schools and the building of new schools, to provide accommodation for an annual intake of 1,000 students. The Report of the Committee is at present under consideration by the Government.

Proportion of doctors and dentists in the National Health Service

7. The National Health Service is by far the largest field of employment for doctors and dentists. Out of about 53,000 doctors practising whole or part-time in Great Britain in June, 1955, about 43,000 were in general practice in the National Health Service or in the hospital and specialist services branch of that Service. There are at present about 15,000 registered dentists in Great Britain of whom the great majority are believed to be practising. Of these nearly 10,000 are in general dental practice in the National Health Service or in the hospital and specialist services branch of that Service.

PART II: HOSPITAL AND SPECIALIST SERVICES

(N.B. Throughout this Part the phrase "the Terms and Conditions of Service" is used as an abbreviation for "the Terms and Conditions of Service of Hospital Medical and Dental Staff".)

The Pattern of the General Organisation of Medical and Dental Staff

8. Under the Medical Act, 1956, medical students must, after passing their qualifying examinations—which is generally when they are between 23 and 25 years of age—gain experience as a resident house officer for a prescribed period in approved hospitals before they become eligible for full registration as medical practitioners. On being accepted for a house officer post in an approved hospital a newly qualified person must apply to the General Medical Council for provisional registration in order to enable him to undertake this employment and subsequent employment of a similar nature. A provisionally registered person is, under Section 17 (3) of the Act of 1956 deemed to be registered as far as is necessary for the purpose of engaging in employment of this nature, but not further.

9. Regulations made by the General Medical Council prescribe that the period for which an applicant for full registration shall have been engaged in hospital employment as a house officer under these arrangements shall be twelve months. The duration of a post as house officer is six months and normally the provisionally registered practitioner spends six months in a medical post and six months in a surgical post or, in place of one of these, six months in a midwifery post.

10. After full registration is obtained, further house officer hospital posts are sometimes taken. It is rare for more than four posts to be held. At present about half the male practitioners go into the Forces for National Service soon after becoming fully registered but this is to be reviewed in the light of the Government's decision to end National Service by 1962.

11. There are six grades of hospital staff above the house officer grade. They can be defined only in relation to one another and are:—

- (a) *Senior house officer*: These are posts obtained after at least two house officer posts and held for one year only. Some practitioners hold more than one such post.

- (b) *Junior hospital medical officer* : The officers in this grade are defined by the Terms and Conditions of Service as officers who have held house appointments but are not registrars and have less responsibility than other officers of non-consultant status. There is no requirement in the Terms and Conditions of Service that these posts shall be of limited duration but it has been agreed with the profession that they can be and they often are.
- (c) *Registrar* : This is usually the next post after a senior house officer post and a post of this kind is normally held for two years. Some doctors hold more than one such post.
- (d) *Senior registrar* : This post, which usually follows one or more posts as registrar, is normally held for four years.* This is the training grade for consultant posts.
- (e) *Senior hospital medical officers* : These officers are described by the Terms and Conditions of Service as officers performing clinical duties who are not of consultant status but are not registrars. New appointments are usually made from applicants who have held posts in the grade of senior registrar or registrar.
- (f) *Consultant* : New entrants to the grade come mostly from the senior registrar grade (including university teachers of similar clinical status) but some come from the senior hospital medical officer grade.

Appointments in the consultant and senior hospital medical officer grades are normally of unlimited tenure, subject to a specified retiring age which is 65 normally but may, in the individual case, be extended up to 70.

12. The general plan of the staffing structure is that a doctor who wishes to make his career in the hospital service will pass through a series of posts of short-term duration from house officer at the bottom to, in most cases, senior registrar at the top before he becomes a candidate for a senior post with unlimited tenure.

13. The main difference in the case of dental staff is that dental students become eligible for full registration as dentists immediately on passing their qualifying examinations and are not required to undertake a year's hospital work as provisionally registered practitioners. Dentists generally qualify between the ages of 22 and 24. The general structure of dental staff in the Hospital Service is identical in pattern with that of the medical staff but fewer newly qualified dentists spend time in hospital posts; first come the two house officer grades, then the two registrar grades and finally the senior hospital dental officer and consultant grades. The Terms and Conditions of Service describe senior hospital dental officers as senior officers:

"In dental hospitals or departments who are not of consultant status but are not registrars, and either:

- (i) perform clinical dental teaching duties
- (ii) perform clinical dental duties beyond the scope of a general dental practitioner and are distinguished by their standing, experience or qualifications from general dental practitioners".

Numbers and Total Cost of Medical and Dental Staff

14. The total number of practitioners (including honorary staff) employed in the grades of consultant, senior hospital medical officer, senior hospital dental officer, senior registrar, registrar, junior hospital medical officer, senior house officer and house officer was about 20,400 at the end of 1955, the latest date for which information is available. It is not likely to have varied greatly

* Until 1952 the recognised normal period of tenure was three years.

since that date. The figure includes general practitioners who worked part-time in the Hospital Service in one of those grades but it does not include general medical practitioners who were members of the staff of general practitioner hospitals or employed as part-time medical officers in convalescent homes or as part-time clinical assistants or general dental surgeons employed in a non-specialist capacity in hospitals.

The total remuneration of hospital medical and dental staff in the financial year 1955-56 was £36,018,667, including the value (8 per cent) of the Exchequer contribution to superannuation and the employers' share of the National Insurance contribution. The division of this payment between the main categories of staff was—

	£
To consultants	21,799,146
To Senior Hospital Medical and Dental Officers, Senior Registrars and Registrars	8,453,433
To other medical and dental staff	5,766,088
	<u>36,018,667</u>

The total remuneration year by year since 1st April, 1949, is given below:—

	£
1949-50	25,156,616
1950-51	29,170,508
1951-52	28,209,707
1952-53	29,481,811
1953-54	30,719,485
1954-55	34,893,738
1955-56	36,018,667

In addition there have been minor payments to junior medical staff, e.g., those engaged in the Blood Transfusion and Mass Radiography Services. Details of these payments are not available.

15. The approximate number employed in the general grades at the end of 1955 were:—

Grade	Medical	Dental
Consultants	7,240	280
Senior hospital medical officers	2,640	—
Senior hospital dental officers	—	260
Senior registrars	1,260	50
Registrars	2,620	60
Junior hospital medical officers	760	—
Senior house officers	2,030	20
House officers	3,200	—
Total	20,420	—

The above figures include practitioners holding honorary appointments; about 475 in the grade of consultant, about 20 in that of senior hospital medical (dental) officer and about 110 in that of senior registrar.

Appendix A shows the estimated number employed in those grades at the end of each year from 1951 to 1955.

16. The figures are of the number of individuals employed: each doctor and dentist is counted as one irrespective of whether he is employed whole-time or part-time. The figures for consultants, and to a lesser though still substantial extent, those for senior hospital medical officers and senior hospital dental

officers, include many doctors and dentists who work in the hospital service for only part of their time, being engaged also in private specialist practice, or in teaching or research (and holding honorary appointments only in the hospital service) or in general practice. The numbers of consultants and senior hospital medical and dental officers employed on whole-time and part-time contracts at the end of June, 1956, *excluding those holding honorary hospital appointments* were as follows:—

Grade	Whole-time	Part-time	
		Number	Average No. of sessions* worked per practitioner per week
Consultants Medical	2,283	4,734	7.7
Consultants Dental	27	189	3.6
Senior hospital medical officers	1,477	1,139	4.2
Senior hospital dental officers	67	190	2.3

17. The part-time appointments are not, however, evenly spread between specialties as will be seen from the following figures of the distribution of specialists among the various specialties at the same date:—

*Distribution by Specialities
June, 1956*

Speciality	Consultants			Senior Hospital Medical (Dental) Officers		
	Whole-time Number	Part-time		Whole-time Number	Part-time	
		Number	Sessions		Number	Sessions
General Medicine	170	675	4,920	102	128	477
Diseases of the Chest	268	76	464	417	29	163
Mental Illness	423	197	1,241	338	84	355
Neurology	9	57	402	4	2	5
Pædiatrics	41	164	1,273	10	11	37
Radiology	201	267	2,139	46	22	92
Radiotherapy	76	44	369	36	4	22
Physical Medicine	19	58	407	10	17	72
Pathology	444	91	733	174	10	51
Infectious Diseases	37	17	67	39	41	130
Dermatology	4	146	1,007	2	37	109
Venereology	32	60	360	33	47	186
Ophthalmology	11	325	2,274	26	224	1,053
General Surgery	155	793	6,387	56	149	472
Anæsthetics	183	624	5,181	89	222	1,023
Neurosurgery	17	35	298	1	—	—
Plastic Surgery	8	40	318	1	—	—
Thoracic Surgery	23	72	566	1	—	—
Orthopaedic Surgery	59	289	2,426	52	22	117
Ear, Nose and Throat	30	313	2,529	7	30	151
Obstetrics and Gynaecology	73	391	3,168	33	60	278
	2,283	4,734	36,529	1,477	1,139	4,795
Dentistry	27	189	676	67	190	440

- Notes:
- (1) About 140 practitioners follow two specialities and are counted in both.
 - (2) Holders of honorary appointments are not included.

* A session connotes an undefined period of continuous work in the morning or afternoon. It is not identical with a "notional half-day". Information about the number of notional half-days worked by part-time staff is not available.

Remuneration and other Terms and Conditions of Service of Hospital Medical and Dental Staff. Development of Current Rates of Pay

The Spens Committee

18. In 1947, in preparation for the inception of the National Health Service the Minister of Health and the Secretary of State for Scotland appointed a committee to consider :—

“ what ought to be the range of total professional remuneration of registered medical practitioners engaged in the different branches of consultant or specialist practice in any publicly organised hospital and specialist service ; to consider this with due regard to what have been the financial expectations of consultant and specialist practice in the past, to the financial expectations in other branches of medical practice, to the necessary post-graduate training and qualifications required and to the desirability of maintaining the proper social and economic status of specialist practice and its power to attract a suitable type of recruit, having regard to other forms of medical practice ; and to make recommendations.”

Committees had previously been appointed with similar terms of reference in relation to general medical practitioners and general dental practitioners, the committee on general dental practitioners later having its terms of reference extended to cover the remuneration of dental consultants and specialists as well. These three committees were under the chairmanship of Sir Wills Spens and have become known as the Spens Committees.

19. The Committee on Consultants and Specialists indicated in their report* that they had taken the following general factors into consideration :

- (1) The career picture of the past (section 4 of the report).
- (2) The financial conditions and expectations in the past including the salary scales for doctors in salaried employment (sections 1 and 5).
- (3) The long period of training required in some of the more specialised branches of medicine and the fact that criteria for recognition of specialist status† involving a minimum period of five years of training after medical qualification or eleven years' professional training in all had been proposed by many groups of consultants and specialists (section 6).

and that they based their recommendations on the principles that—

- (a) All specialists irrespective of their speciality should be remunerated within the same range of incomes (section 7).
- (b) The same range of remuneration should apply to specialists in all hospitals whether the hospitals be teaching or non-teaching. The Committee, however, saw no objection to a combination of clinical work and teaching work attracting higher pay than clinical work alone (Sections 8 and 14).

20. The Committee prefaced their recommendations on the remuneration of potential specialists, after completing one year's house appointments and before obtaining a staff appointment, by the following statement :

“ We are of opinion that in a public service intending specialists who do not possess private means should not be called upon to pass through

* Report of the Inter-departmental Committee on the Remuneration of Consultants and Specialists. (Cmd. 7420.)

† Though in section 3 of their report the Committee stated that they had decided to interpret the term “ specialist ” so as to include the whole group of practitioners who after registration and completion of junior house appointments are appointed to hospital posts in training for a special branch of medicine, they did not invariably use the term in the defined sense.

a stage of comparative penury and hardship. Nor should they be tempted to spend too much time in supplementing their income from other sources, such as coaching, when they could be more suitably occupied in their professional studies. Having regard to the career picture which we have drawn from the evidence, we consider that the medical practitioner, between the completion of his first house appointment and appointment to the staff, should be paid a salary which is not merely in the nature of a training grant but which reflects both the growth in his skill and the increasing responsibility of his work."

21. The Committee's recommendations on the remuneration of whole-time potential specialists were as follows:—

<i>Grade</i>	<i>Salary recommended</i>
Grade III: posts obtained normally not less than one year after registration and held normally for one year only (e.g., senior house officer, resident medical officer, etc.).	A fixed salary of £600.
Grade II: posts obtained normally not less than two years after registration and held normally for two years at the ages of 26 and 27 (e.g. assistants, junior registrar, etc.).	£700 rising by one annual increment of £100 to £800.
Grade I: posts obtained normally not less than four years after registration and held normally for three years at the ages of 28, 29 and 30 (e.g. first assistant, chief assistant, senior registrar, etc.).	£900 rising by two annual increments of £100 to £1,100: where tenure continues beyond three years there should be a further increment to £1,200 in the further year and remain at this figure in any further years.

By way of comment on the definitions of the grades the Committee said:

"These definitions avoid difficulties of nomenclature and are sufficiently flexible to admit of general application; a longer or shorter time than that stated in the definitions might be spent in any of these grades. Nevertheless, by indicating a general standard related primarily to the length of time after registration, the definitions have regard to age, which at this stage of the specialist's career is a most important factor."

22. The Committee further indicated that these recommendations related to non-resident posts and that where residential emoluments were received an appropriate sum would need to be deducted from the salary (Section 9).

23. In approaching the question of remuneration for consultants the Committee addressed themselves to the problem of determining the total range of remuneration for consultants, of full staff status, and of securing within this range sufficient differentiation of incomes to provide the necessary incentives consistently with the principles which the Committee had postulated that there should be no differentiation of remuneration between specialties or between hospitals (Section 10).

24. The Committee recommended that the starting salary of a whole-time specialist on appointment to the hospital staff should be £1,500 per annum, rising by annual increments of £125 provided he had attained the age of 32 which they thought would be a normal age. Where a staff appointment was

not obtained for some years after the age of 32—which they visualised might often happen—they recommended that the hospital authorities should have freedom to allow a higher starting salary to be given by allowing up to four special increments of £125 each in respect of age, special experience and qualifications. Where an appointment to the staff was obtained at or below the age of 30—which they considered would be exceptional—they recommended a starting salary of £1,250, and where one was obtained at the age of 31 they recommended a starting salary of £1,375 (Section 11).

25. On the question of the maximum figure of remuneration the Committee considered that the figures placed before them of the earnings of consultants and specialists* in 1938-39:—

“show that it has been possible for a small proportion of practitioners in the past to obtain incomes of a very high order. Bearing in mind that the salaries we have recommended above would remove the hardships at present experienced during the period of training; that in a public service the specialist ought not at any stage of his career to require to supplement his earnings by private means; that his remuneration will be maintained at a consistent level until the age of retirement is reached; and that throughout his career the specialist will enjoy financial security in marked contrast with the uncertainties of private practice, we concluded that some reduction was justifiable not only in the ceiling figure of the incomes attainable in the past, but also in the proportion of consultants attaining to the highest levels of remuneration. On the other hand, we would emphasise that if the best possible recruits are to be attracted to specialist practice, there must remain for a significant minority the opportunity to earn incomes comparable with the highest which can be earned in other professions. There is a further point to which we attach great importance. We are convinced that the remuneration offered to specialists of exceptional ability must be sufficient not only to attract the most able specialists of this country to the public service, but to maintain the position of British Medicine in a competitive market which includes the Dominions and the United States of America.

After consideration of these factors we concluded that specialists of the highest eminence should be able, in the public service, to aspire to a remuneration of the order of £5,000 for clinical work”. (Section 12.)

26. Turning to the question of what should be the spread of incomes within the range of £1,500—£5,000 the Committee were satisfied that—

“there is a far greater diversity of ability and effort among specialists than admits of remuneration by some simple scale applicable to all. If the recruitment and status of specialist practice are to be maintained, specialists must be able to feel that more than ordinary ability and effort receive an adequate reward. Moreover, a reward which would be appropriate when these exist would be extravagant when they do not. In consequence we are clear that any satisfactory system of remuneration must involve differentiation dependent on professional distinction.” (Section 13.)

This did not mean that they considered that age or length of service should not affect remuneration and they qualified their adoption of that principle of differentiation based on professional distinction in the following comment:—

“we were agreed that after his appointment to the staff of a hospital, the specialist, although his training is complete and he undertakes sole

* As to the practitioners, covered by the figures, see sections 1 and 5 of the report and the second, third and seventh paragraphs of Appendix II thereto.

personal responsibility for the patients under his charge, continues for a number of years to gain an increasing variety and width of practical clinical experience which progressively enhances the value of his work. It seems to us, therefore, that, whilst age or length of service should not at any time during his tenure of a staff appointment be the sole factor determining remuneration, there should be, during the earlier years, in addition to some means of recognising and rewarding exceptional individual merit, a uniform scale of annual increases in remuneration applicable to all specialists alike." (ibid)

They then recommended that the initial salary paid to a whole-time specialist on obtaining a staff appointment should be augmented by annual increments of £125 until a figure of £2,500 had been reached. They added the comment:

"We consider that beyond this point, which if staff status is achieved at the age of 32 would be the age of 40, an incremental basic scale of remuneration would be inappropriate, and remuneration should cease to depend in any way at all upon the length of service of the specialist." (ibid)

and they proceeded to recommend the institution of a system of distinction awards under which some specialists would be able to qualify for a total salary at the rate of £5,000 per annum. (ibid). Recommendations were also made on remuneration for part-time employment, expenses and holidays. Further reference is made to distinction awards and these other matters in later paragraphs of this memorandum.

27. The Committee (like the other Spens Committees) expressed their recommendations on remuneration in terms of 1939 monetary values. They said on this subject:—

"At an early stage in our deliberations it appeared to us that social and economic conditions were not yet sufficiently stable to justify the basing of our recommendations on evidence relating to remuneration in the post-war period, and the Evidence Committee* was accordingly asked to obtain information of incomes earned in the year 1938-39. With this evidence before us, and realising that we were not qualified as a Committee to form an opinion on what adjustment of immediately pre-war incomes was necessary to produce corresponding incomes today, we decided that the best course for us to pursue was to frame our recommendations in terms of the 1939 value of money. This conclusion has not prevented us from taking into account post-war conditions in so far as they affect the development of Medicine, particularly in regard to developments in the newer specialties and to modifications in the organisation of hospital services. We leave to others the problem of the necessary adjustments to present-day values of money, but we desire to emphasise as strongly as possible that such adjustments should have direct regard not only to estimates of the change in the value of money but to the increases which have in fact taken place since 1939 in incomes both in the medical and in other professions. In our judgment it is only if corresponding changes are made in the incomes of consultants and specialists that the recruitment and status of the various branches of specialist practice will be maintained." (Section 2).

* This was a joint Committee set up by the Royal Colleges and British Medical Association to prepare evidence for submission to the Spens Committee. It was from the Evidence Committee that the Spens Committee obtained evidence about earnings in 1938/39.

28. When announcing, on 3rd June, 1948, in the House of Commons, that the Report would be published the next day, the Minister of Health of the time made the following statement of the Government's attitude:

"I should like to add that this Government accept the recommendations in principle. The task of evolving from it [the report] the best schemes of actual remuneration—to suit all cases—and especially the bearing of the recommendations on remuneration for teaching duties—will be difficult and will require the help of the profession in discussion. I propose to begin this quickly, but whatever final scheme emerges will be deemed to operate from the 5th July even if discussions carry on past that date."

The Report of the Spens Committee on the remuneration of dentists (see also paragraph 153) recommended in paragraph 23 that dental specialists with training and qualifications comparable with medical specialists should be similarly remunerated. This recommendation was adopted by the Government.

Original Salaries in the Terms and Conditions of Service

29. The Terms and Conditions of Service accepted by the professions after negotiations, provided for salaries from 5th July, 1948 (the date of inception of the National Health Service) which were about 20 per cent. above salaries in pre-war terms recommended by the Committee, taking account of the value of the contribution to be made by the Exchequer to superannuation (see paragraph 81 below). No addition was made to the actual amounts (£2,500, £1,500 and £500) recommended for distinction awards, but awards became superannuable earnings and the holders accordingly had the benefit of the Exchequer superannuation contribution on the awards payments as well as on their basic salaries. The Terms and Conditions incorporated a salary for house officers (a grade on which the Committee had not made a recommendation) and provided for the introduction of two grades not covered by the Committee's recommendations—senior hospital medical officers and junior hospital medical officers. Under the Terms and Conditions of Service dentists in the various hospital grades were given the same salary scales as their medical counterparts. The Spens recommendations on salary rates and the rates which actually operated from 5th July, 1948, are set out in Appendix B.

Establishment of Whitley Machinery for the Medical Grades.

30. The negotiations which led to the profession advising hospital staff to sign contracts on those Terms and Conditions of Service took place at a time when discussions were also proceeding on the establishment of Whitley machinery for considering the remuneration and conditions of service of the various classes of staff engaged in the National Health Service and in the course of those negotiations the following assurance about the establishment of Whitley machinery for hospital medical staff was given on behalf of the Government:—

1. No changes will be made in the terms and conditions of service without discussion in the appropriate part of the Whitley machinery when established, and this will be established as soon as possible.
2. Remuneration is a subject which is suitable for arbitration.
3. Save in exceptional circumstances, and after the conciliation machinery of Whitley has been exhausted, issues of remuneration remaining in dispute will go either to arbitration or for enquiry and report by a Committee.*

* Supplement to the British Medical Journal, 23rd July, 1949, p. 53.

31. In 1950, a Medical Whitley Council was established as one of the Whitley Councils for the Health Services (Great Britain). A copy of the Council's constitution is appended (Appendix C). It will be seen that it makes provision for the appointment of a committee (Committee B) to deal with the remuneration and conditions of service of medical practitioners employed by Regional Hospital Boards, Boards of Governors of Teaching Hospitals, Hospital Management Committees or Boards of Management. Committee B was duly appointed in 1950. The Management Side consists of representatives of the Regional Hospital Boards, Boards of Governors and Hospital Management Committees, who together constitute a majority, and representatives of the Ministry of Health and the Department of Health for Scotland. The Associations of Local Authorities are free to send two observers to meetings of the Management Side and of the full Committee.

32. The constitution of the Medical Whitley Council provides that where a difference between the two Sides of the Council or a Committee cannot be resolved either Side may seek arbitration in accordance with an arbitration agreement to be determined by the General Whitley Council for the Health Services (Great Britain). Such an arbitration agreement has not yet been concluded. There is, however, provision for dealing with disputes within the National Health Service on the same lines as disputes in other fields. Under Section 13 of the National Health Service Amendment Act, 1949, any difference or dispute arising with respect to the remuneration or conditions of service of persons working in the National Health Service is within the scope of the Conciliation Act, 1896, and the Industrial Courts Act, 1919. When a dispute occurs the services of the Ministry of Labour are available and the two parties may agree to the dispute being referred to the Industrial Court or, if preferred, to some other form of arbitration such as a single arbitrator. Neither party is, however, free to resort to arbitration without the consent of the other. Several disputes have been referred to arbitration.

There is no Whitley Council for the dental grades. The British Dental Association have hitherto preferred that discussion and negotiations on matters affecting the remuneration and other terms and conditions of service of those grades should take place direct between them and the Health Departments, but recently the Associations have suggested that the dental grades in the Hospital Service should be brought within the scope of Committee B of the Medical Whitley Council.

Later Changes in Salaries

33. Following the adjudication by Mr. Justice Danckwerts on the size of the Central Pool for general practitioners (see paragraphs 123-126) the Staff Side of Committee B submitted to the Management Side a claim for increased rates of pay for hospital medical staff. After long negotiations—an account of which by the Chairman of the Staff Side appeared in the British Medical Journal for 10th April, 1954 (reproduced in Appendix D)—agreement was reached for increases in pay from 1st April, 1954. The rates of pay which were brought into effect then are shown in Appendix B.

34. Later a difference arose on Committee B on a claim presented by the Staff Side for a further increase for senior hospital medical officers. With the consent of the Management Side the difference was referred to arbitration by the Industrial Court. The Court awarded an increase of £75 a year from 26th April, 1956. The cases presented by the two Sides are summarised in the Court's award.* By agreement between the British Dental Association and the Health Departments this increase was given also to Senior Hospital Dental Officers.

* Industrial Court (2606): National Health Service.

Current Salary Rates

35. In the course of a statement made in the House of Commons on 12th March, 1957, on the appointment of the Royal Commission, the Prime Minister stated:—

"I have already explained that the appointment of the Commission does not preclude an interim adjustment in advance of and without prejudice to its recommendations. The Government have already decided to make such an adjustment without delay in the remuneration of junior hospital staff, both medical and dental, up to and including the grade of senior registrar, all of whose remuneration will be increased by 10 per cent from 1st April next. We are also considering what should be done by way of an interim adjustment for the other doctors and dentists covered by the Commission's terms of reference. I shall make a further statement on this matter in due course."

The Prime Minister made a further statement on 16th April, in the course of which he announced that the Government had now decided, as a similar interim measure, to increase the basic remuneration of senior hospital medical and dental staff including consultants and specialists by 5 per cent from 1st May. With these increases the current salary scales for whole-time service became:—

Consultant (without Distinction Award).	£1,890 (at age 30 or less). £2,047 10s. (at age 31). £2,205 (at age 32 or over)* × £131 5s. (8) = £3,255.
Senior hospital medical officer	{ £1,548 15s. (at age 30 or less). £1,601 5s. (at age 31). £1,653 15s. (at age 32 or over)* × £52 10s. (9) = £2,126 5s.
Senior hospital dental officer ...	
Senior registrar	£1,210 in the first year. £1,320 in the second year. £1,430 in the third year. £1,540 in the fourth and any subsequent years.
Registrar	£935 in the first year. £1,061 10s. in the second and any subsequent years.
Junior hospital medical officer	£852 10s. × £55 (6) = £1,182 10s.
Senior house officer	£819 10s.
House officer	At the rate of £467 10s.; £522 10s.; or £577 10s. per annum for each post of six months' duration.

Part-time Remuneration

Consultants

36. The Spens Committee made the following recommendation about the determination of the remuneration for specialists who are engaged part-time in the Hospital Service:—

"On the assumption that a specialist in whole-time service would undertake a working week of eleven half days we suggest that the part-

* Where appointment is obtained after age 32 the employing authority has discretion to give a starting salary up to four increments above the normal minimum for age 32 or more on grounds of age, experience and qualifications, provided that the appointee is not given a higher salary than he would have been entitled to had he entered the scale at age 32.

time specialist should be required to devote to the Service a specified number of half-days per week. On this basis we recommend that where x represents the number of half-days per week which the part-time specialist is required to work, his basic remuneration should be $\frac{x}{11}$ of the basic remuneration of whole-time specialists of like status, plus one-quarter of $\frac{x}{11}$ or one-quarter of $\frac{11-x}{11}$ of that remuneration, whichever be least."

The Committee recommended that hospital authorities should be free in special circumstances to offer, at least temporarily, a higher rate of remuneration for part-time appointments than would be produced by the foregoing recommendation (section 15 of the report).

37. In explanation of the recommended "weighting" the Committee said:—

"In our view the responsibilities and commitments of a part-time appointment cannot be measured in relation to those of a whole-time appointment simply by comparing the total working hours of the part-time officer with the total working hours of his whole-time colleague. The specialist who holds a part-time hospital appointment has a continuous responsibility for the patients in his charge, which must extend beyond the limits of the time he contracts to serve: further, he will be expected to take his share in the committee work of the hospital, and this must encroach upon time which would otherwise be spent in private practice. In assessing the remuneration which shall attach to part-time appointments such factors must be taken into account." (section 15 of the report).

38. Under the Terms and Conditions of Service the number of hours per week for which a part-time specialist should be paid must be determined as follows:—

"The Board shall assess in terms of hours per week what is the average amount of time required by an average practitioner to perform the duties attaching to the post. In assessing the average amount of time to perform the duties attaching to the post the Board shall take into account out-patient clinics, ward rounds, operating sessions, laboratory work and so on in their hospitals, including occasional visits to outlying hospitals for consultation, diagnosis or operative work. The Board shall also include time given, e.g. as Consultant Adviser to the Board on special branches of the Service or by way of "pastoral visits" to outlying hospitals; and time necessarily required in travelling between home or private consulting room (whichever is the nearer) to the hospital or hospitals served (unless the journey is one which the consultant would undertake irrespective of his work for the Board). There shall be excluded from the computation any element of time for emergency calls by consultants to patients in the beds in their charge (except where any exceptionally heavy liability to recurring emergency work of this sort is anticipated), or for committee work, or for the care of private patients in pay beds or as out-patients. There shall also be excluded time required for domiciliary visits for which special fees are payable."

Under an agreement reached with the profession after this provision of the Terms and Conditions was originally promulgated, the amount of travelling time that may be counted as "time necessarily required in travelling between home or private consulting room . . . to the hospital or hospitals served" is a maximum of half an hour each way in respect of journeys to and from the practitioner's main hospital unless the circumstances of the individual warrant exceptional treatment.

39. The amount of time required for the duties of the post as determined in that manner is converted into "notional half-days per week" for assessing the amount of remuneration due by way of salary. The rule for calculating the number of notional half-days per week is set out as follows in the Terms and Conditions of Service:—

"The number of notional 'half-days' shall be arrived at from the aggregate of hours so assessed, by dividing the total by $3\frac{1}{2}$, the consultant being given the benefit of the marginal overlaps as follows:—

<i>No. of hours weekly</i>	<i>No. of notional half-days on which salary will be reckoned</i>
Up to $3\frac{1}{2}$	1
Over $3\frac{1}{2}$ and up to and including 7	2
Over 7 and up to and including $10\frac{1}{2}$	3
Over $10\frac{1}{2}$ and up to and including 14	4
Over 14 and up to and including $17\frac{1}{2}$	5
Over $17\frac{1}{2}$ and up to and including 21	6
Over 21 and up to and including $24\frac{1}{2}$	7
Over $24\frac{1}{2}$ and up to and including 28	8
Over 28	9

40. The amount of remuneration payable for work under part-time contracts for these numbers of half-days was originally determined by the formula quoted in paragraph 36, the effect of which was to weight the amount produced by a straight division of the whole-time salary into elevenths. The weighting was modified as part of the agreement reached on the Medical Whitley Council in 1954 on new salary scales to operate from 1st April of that year. A comparison of the two weightings is made in the following table:—

Number of notional half-days on which part-time remuneration is reckoned (see paras. 38 and 39)	Original Weighting			Weighting under 1954 Agreement		
	Weighting expressed in terms of notional half-days	Weighting expressed as a percentage of the notional half-days in col. (1)	Proportion of whole-time salary payable Per cent.	Weighting expressed in terms of notional half-days	Weighting expressed as a percentage of the notional half-days in col. (1)	Proportion of whole-time salary payable Per cent.
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1	$\frac{1}{11}$	25	11	$\frac{1}{11}$	25	11
2	$\frac{2}{11}$	25	23	$\frac{2}{11}$	25	23
3	$\frac{3}{11}$	25	34	$\frac{3}{11}$	25	34
4	$\frac{4}{11}$	25	45	$\frac{4}{11}$	19	43
5	$\frac{5}{11}$	25	57	$\frac{5}{11}$	15	52
6	$\frac{6}{11}$	21	66	$\frac{6}{11}$	13	61
7	$\frac{7}{11}$	14	73	$\frac{7}{11}$	11	70
8	$\frac{8}{11}$	9	80	$\frac{8}{11}$	9	80
9	$\frac{9}{11}$	6	86	$\frac{9}{11}$	6	86

It will be seen that the change affected consultants doing from 4 to 7 notional half-days. Whereas the remuneration payable for 5 notional half-days a week had hitherto been $6\frac{1}{2}$ elevenths (or 57 per cent) of the whole-time salary, under

* As a notional half-day relates to a period of up to and not more than $3\frac{1}{2}$ hours, irrespective of whether this period is all in one half of a day or partly in one day and partly in another, it is to be distinguished from a session as used in paragraphs 16 and 17.

the agreement of 1954 it became $5\frac{1}{2}$ elevenths (or 52 per cent). Consultants already under contract had the protection of a "no detriment" provision in respect of the effects of the agreement as a whole.

41. $9\frac{1}{2}$ elevenths of the appropriate whole-time remuneration (including the value of any distinction award) is the maximum remuneration a part-time consultant may be paid, apart from fees for exceptional consultations, domiciliary consultations and payments made in respect of work as locum tenens (see paragraphs 64-71).

42. Appendix E sets out the amount earned by consultants doing different numbers of half-days when they are at the minimum point of the main salary scale (£2,205 for a whole-time officer aged 32 or over) and also when they are at the maximum of the scale £3,255 for a whole-time officer).

Senior Hospital Medical and Dental Officers

43. The salaries of part-time officers are calculated in exactly the same way as the salaries of part-time consultants. Senior hospital medical and dental officers are not eligible for distinction awards.

44. The salaries of part-time officers doing different numbers of notional half-days at the minimum of the scale and at the maximum are set out in the Appendix E.

Registrar and House Officer Grades

45. The salaries of part-time officers in the four registrar and house officer grades (of whom there is not a great number) are calculated without "weighting": that is to say, where the number of notional half-days (which is calculated on the basis laid down for consultants) is x , the proportion of the appropriate whole-time salary to be paid is $\frac{x}{11}$.

Other Grades of Medical and Dental Staff

46. In addition to the grades mentioned above, the Terms and Conditions of Service make provision for:—

- (a) medical superintendents and deputy medical superintendents
- (b) general medical practitioners working on the staff of general practitioner hospitals (cottage hospitals) other than maternity hospitals
- (c) general medical practitioners employed as part-time medical officers at convalescent homes, general practitioner maternity hospitals, or other types of hospital where no other settled rate of pay is appropriate
- (d) general dental practitioners undertaking general dental work at hospitals.

47. Under an agreement reached on Whitley Committee B following an award of the Industrial Court* in an arbitration between the two Sides of the Committee, the remuneration of a *medical superintendent* depends in England and Wales upon whether he is engaged in clinical work as well as administrative work and, where he is, upon the extent and grade of his clinical work. Where a medical superintendent is normally engaged for 32 hours a week or more in clinical duties he is paid as if all his duties were clinical, i.e., if his clinical grading is as a consultant he is paid as a consultant for his administrative as well as his clinical work. If, on the other hand, he is engaged wholly on administrative duties he is paid a salary between £1,500 a year

* The award, which is published (Industrial Court (2357) National Health Service) summarises the cases presented by the two Sides.

and £1,900 a year according to the size of his hospital. Where a medical superintendent's duties are not wholly administrative and his clinical duties do not normally occupy as much as 32 hours a week, he is paid a "mixed" salary comprising separately calculated elements for his administrative work and his clinical work. The detailed rules for the calculation of the salary of a medical superintendent who spends all his time in administrative work or who has an appointment with mixed duties are set out in Appendix F.

48. The remuneration of a *deputy medical superintendent* of a hospital in England and Wales is determined by the same method as that of a medical superintendent except that any administrative element in his salary is calculated at 66½ per cent. of the rate appropriate to a medical superintendent.

49. The number of medical superintendents and deputy medical superintendents in England and Wales at 31st December, 1955, was as under. They were mostly employed at hospitals for diseases of the chest or for mental illness or mental deficiency.

			<i>Whole-time</i>	<i>Part-time</i>
Medical Superintendents	...	...	77 (93)	18 (21)
Deputies	...	...	53 (62)	2 (3)

The figures in brackets are the number of sessions undertaken by these practitioners which are remunerated at the administrative rate. Under 10 Medical Superintendents are engaged whole-time on administrative duties.

50. Medical Superintendents of general hospitals in Scotland are whole-time administrative officers. Each is in charge of the medical administration of a hospital or group of hospitals, the number of hospitals in the latter case ranging from 2 to 19. They have no clinical duties assigned to them. At 31st December, 1956, there were 27 Medical Superintendents and 9 Deputies.

51. The salary scales of Scottish Medical Superintendents were negotiated on the appropriate Whitley Council and consist of a series of seven scales ranging from £1,500 to £2,250 and dating from 24th September, 1955. The scales are graded to take account of the different sizes of hospital groups and the load falling upon the hospitals. The particular scale to be selected for each group is negotiated through the Whitley Council machinery. As in England and Wales a Deputy is paid two-thirds of the scale applicable to the Medical Superintendent under whom he works.

52. *General Medical Practitioners on the staff of general practitioner hospitals (cottage hospitals) other than maternity hospitals.* Regional Hospital Boards have been asked to give an opportunity to all general practitioners practising in an area served by a cottage hospital to accept appointment to the staff of the hospital. The duties include attendance as general practitioners on their own patients in the hospital; sharing with the other members of the staff in attendance on the patients of any practitioners not on the staff; and taking the appropriate share in any emergency in-patient or out-patient work. In so far as general practitioners providing general medical services give hospital care within the scope of these services to patients on their own lists or on those of partners, their remuneration for providing general medical services will already cover that work. But in order to provide remuneration for their hospital work for other patients the Management Committees of these general practitioner hospitals have created staff funds which are shared between the general practitioner on the staff on such bases as these practitioners may themselves determine.

53. Under the Terms and Conditions of Service the Hospital Management Committee of such a hospital makes a payment to the staff fund of a specified

amount per annum for each bed (other than private pay beds and maternity beds) occupied on the average in the hospital. The payment was originally £25 per bed per annum. As an interim measure it was increased from 1st May, 1957 to £26 5s. 0d. per bed.

54. *General Medical practitioners employed as part-time medical officers at convalescent homes, general practitioner maternity hospitals, or other types of hospital where no other rate of pay is appropriate.* Under the Terms and Conditions of Service the rate of pay for general practitioners so employed in the hospital service was originally £175 per annum per notional half-day up to a maximum of £1,575 per annum provided that where the number of hours per week to which services are required is two or less (the hours being calculated according to the formula applicable to part-time specialists) the pay was

1 hour or less	£50 per annum
Over 1 hour but not more than 2 ...	£100 per annum

These figures have all been increased by five per cent from 1st May, 1957, as an interim measure.

55. The primary object of the employment of *general dental surgeons* in the Hospital Service is to provide for the day by day dental care of patients in long-stay hospitals. The salary for whole-time employment was first fixed by the Minister in July, 1952, at £900 x £30 (2)—£960 x £40 (6)—£1,200 x £50 (6)—£1,500: practitioners with more than four years post-registration experience could be given a commencing salary between £900 and £1,000.

56. As from 1st July, 1955, a revised scale of £1,000 x £50 (14)—£1,700 was introduced by agreement between the British Dental Association and the Health Departments. Provision was also made so that a practitioner with more than three years' post-registration experience might be given a starting salary of £1,050, one with four years' experience a salary of £1,100 and one with five or more years' experience a salary of £1,150.

As from 1st May, 1957, the scale has been increased as an interim measure by 5 per cent, to £1,050 x £52 10s. (14)—£1,785.

57. The rate of pay for a part-time general dental practitioner was originally £150 per annum for one notional half-day per week up to a maximum of £1,350 per annum (which would have been produced by nine notional half-days per week). This maximum was reduced to £900 per annum when a rate for a whole-time general dental surgeon was introduced in July, 1952. As from 1st May, 1957, the annual rate for one notional half-day per week has been increased as an interim measure by 5 per cent to £157 10s. 0d. and the maximum limit for earnings from a part-time appointment has similarly been raised by 5 per cent to £945.

58. The number of general dental surgeons employed is :—

<i>Whole-time appointments</i>	<i>Part-time appointments*</i>
12	820

DISTINCTION AWARDS

59. As already mentioned, the Spens Committee recommended that special awards additional to the ordinary salary should be provided for individual specialists whose outstanding distinction merits a higher award. In Section 13 of their report, the Committee remarked :—

"It remained for us to consider in what way a satisfactory spread of incomes could be obtained in the higher age range, and what should be

* More than one part-time appointment may be held by a general dental surgeon and for this reason the number of part-time appointments does not correspond with the number of persons holding them; this number is not known.

the method of differentiation between specialists to achieve this spread of incomes and to ensure that in the lower age range also outstanding ability should be rewarded by remuneration in excess of the basic incremental scale we have already envisaged. Although, as we have said, we are not directly concerned with methods of payment, we are clear that if the profession is to be satisfied and recruitment maintained it is essential that a method of differentiation involving the selection of individuals for exceptional reward in respect of outstanding professional ability must command the confidence of the profession. We have thought it right therefore to indicate the kind of machinery for achieving differentiation which appears to us to be required."

The Committee proceeded to recommend that a national committee, which would be predominantly professional, should be set up to select specialists of staff status (i.e., consultants) for awards which should be conferred "in recognition of special contributions to medicine in the field of research or otherwise, exceptional ability or outstanding professional work (other than administrative)". They further recommended that the highest award should be £2,500 per annum, the second £1,500 per annum and the third £500 per annum, that all specialists of staff status should be eligible, and that of these specialists 4 per cent should have the highest award, 10 per cent the second award and 20 per cent the third.

60. The Committee's recommendations were accepted and the Minister of Health and the Secretary of State for Scotland appointed a standing committee under the chairmanship of Lord Moran of Manton with the following terms of reference:

"To advise the Minister of Health and the Secretary of State for Scotland which specialists engaged in the National Health Service should receive awards for professional distinction, having regard to the desirability that 4 per cent of the number eligible should receive the highest award (at the rate of £2,500 a year) 10 per cent the second award (£1,500 a year) and 20 per cent the third award (£500 a year)".

The Committee consists of 13 other members of the medical profession appointed on the nomination of the Royal Colleges, the Royal Scottish Corporations, the Universities and the Medical Research Council and one layman who is Vice-Chairman.

61. There is a sub-committee of Scottish members, some of whom have been co-opted from outside the main committee, to advise on awards in Scotland; and there is another sub-committee, most of whose members belong to the dental profession, to advise on dental consultants.

62. The number of awards current at 31st December, 1956, was :—

305 of £2,500 a year.
764 of £1,500 a year.
1,528 of £500 a year.

63. A part-time consultant who holds a distinction award receives the same proportion of the whole-time value of the award as he receives of the whole-time basic salary. Clinical teachers and research workers who hold honorary consultant appointments in the Hospital Service are eligible for consideration for awards: the amount payable to those given awards is determined according to the rules set out in Appendix G.

Domiciliary Fees

64. The Spens Committee recommended that additional remuneration should be paid in respect of domiciliary visits because the need for such visits would not be uniformly distributed as between different specialties and because of the very considerable additional burden which they would place on the consultants undertaking them (section 7 of the report).

65. The Terms and Conditions of Service provide that when a part-time consultant undertakes a domiciliary consultation* he becomes entitled to a fee of 4 guineas with an additional fee of:—

- (1) 2 guineas where any operative procedure other than obstetric is undertaken or where he uses his own electrocardiograph or portable X-ray apparatus.
- (2) 4 guineas for an obstetric operation.

The amount which any consultant may earn in a year by way of these domiciliary fees is subject to a maximum of 800 guineas.

66. Where a visit involves a journey to a place 20-40 miles away an additional payment of one guinea is made over and above the normal travelling and subsistence expenses. If the journey is to a place more than 40 miles away an extra guinea is payable for every 20 miles or part thereof.

67. Before November, 1955, a whole-time consultant was not entitled to extra remuneration for domiciliary consultations. Under an agreement reached on Whitley Committee B he has, since that date, been entitled to the same fees as a part-time officer for any domiciliary consultations in excess of eight in a quarter, subject to a maximum of 800 guineas in a year. By agreement between the British Dental Association and the Health Departments the same arrangement applies to whole-time dental consultants.

68. When senior hospital medical and dental officers are called upon to make domiciliary visits they are eligible for domiciliary fees of the same amount and on the same basis as consultants. Senior hospital medical and dental officers normally undertake domiciliary consultations only where there are insufficient consultants.

69. The table below shows, for England and Wales, the numbers of practitioners undertaking domiciliary work and the number of visits made:—

Year	No. of practitioners undertaking domiciliary work at 31st December		No. of visits entailing only consultations		No. of visits entailing operative procedures and/or use of practitioner's apparatus		Total No. of Visits		Visits per practitioner	
	Cons.	SHMO.	Cons.	SHMO.	Cons.	SHMO.	Cons.	SHMO.	Cons.	SHMO.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
1950 ...	4,916	771	145,855	15,093	7,442	673	153,297	15,766	31	20
1951 ...	5,129	820	152,961	12,730	9,240	573	165,201	13,303	32	16
1952 ...	5,457	726	166,600	8,284	11,212	458	177,812	8,742	33	12
1953 ...	5,551	777	186,742	7,858	13,401	424	200,143	8,282	36	11
1954 ...	5,489	802	202,330	8,703	15,774	472	218,104	9,175	40	11
1955 ...	5,681	867	213,724	9,842	17,654	451	231,378	10,293	41	12

* A domiciliary consultation is a visit to the patient's home, at the request of the general practitioner and normally in his company, to advise on the diagnosis or treatment of a patient who, on medical grounds cannot attend hospital. Visits not falling within this definition include (1) a visit made at the instance of a hospital or specialist to review the urgency of a proposed admission to hospital or to continue or supervise treatment initiated or prescribed at a hospital or clinic; (2) a visit made by a chest physician to a patient on the tuberculosis register of any chest clinic; and (3) a visit undertaken as part of work done for a local health authority.

Exceptional Consultations

70. Where a consultant is called in (e.g., because of his having unusual experience or interest) by a hospital board with whom he has no contract he is entitled to a fee of 5 guineas per visit. No information is available as to the incidence of these consultations.

Locum Appointments

71. The Terms and Conditions of Service envisage that a locum will be employed only when it is impossible to arrange for the regular practitioner's work to be adequately performed by other regular members of the staff. Part-time officers are free to take locum posts. The current locum rates of pay are:—

- (a) Consultant filling a consultant post (or a senior hospital medical or dental officer post)—£5 10s. 3d. per notional half-day if engaged on a part-time basis; or £52 10s. per week if engaged on a whole-time basis.
- (b) Locum other than a consultant filling a consultant or senior hospital medical or dental officer post—£3 17s. 3d. per notional half-day if engaged on a part-time basis; or £34 14s. 6d. per week if engaged on a whole-time basis.
- (c) Locum for part-time medical officer at convalescent homes, general practitioner hospitals or other types of hospital where no other rate is appropriate—£3 17s. 3d. per notional half-day.
- (d) Practitioner doing locum for a senior registrar—£26 8s. per week.
- (e) Practitioner doing locum for a registrar or junior hospital medical officer—£19 5s. per week.
- (f) Practitioner doing locum for a senior house officer—£15 19s. per week.
- (g) Practitioner doing locum for a house officer—£10 9s. per week.

The figures at (a) to (c) include a 5 per cent interim increase from 1st May, 1957; those at (d) to (g) include a 10 per cent increase as from 1st April, 1957.

Other Earnings

72. The medical and dental officer who is employed on a part-time contract is free to engage in private practice for the rest of his time. He may do this entirely outside the Health Service; and he may be allowed to undertake the diagnosis or treatment of patients by private arrangement in accommodation at National Health Service hospitals designated for the purpose by the Minister. There are about 5,700 "pay-beds" so designated. The maximum fees which medical or dental practitioners may charge private patients in National Health Service hospitals are prescribed in the National Health Service (Pay-bed Accommodation in Hospitals, etc.) Regulations, 1953 (S.I. 1953 No. 420). In relation to the services of a medical or dental practitioner other than a consultant, senior hospital medical officer or senior hospital dental officer, the maximum charge for a surgical operation including all attendances and other services rendered is 7 guineas and for each consultation or day of attendance, 15s. up to a maximum of 20 guineas. In relation to the services of a consultant, senior hospital medical officer or senior hospital dental officer, maximum fees are prescribed for various procedures, rising, e.g. for a physician to a fee of 40 guineas for a series of consultations and attendances and for a surgeon to a fee of 50 guineas for a major operation. It is, however, provided that the total cost to a patient, who may be attended by a number of doctors, shall not normally exceed 75 guineas, or with the agreement of the Board or Committee, 125 guineas in certain circumstances.

when treatment is unusually long or complicated and this may reduce the fees payable to any one doctor below the maximum laid down for a particular procedure. A proportion of patients—in not more than 15 per cent of the paybeds at any hospital—may be charged unlimited fees, in agreement with the doctor. The whole-time medical practitioner is specifically precluded from undertaking private practice including unrestricted general practice under Part IV of the National Health Service Acts. Both whole-time and part-time officers may, however, receive payment for professional services which they may be called upon to render which are outside the scope of the hospital and specialist services under the National Health Service Act, 1946. Examples of such "outside" services are set out in the Terms and Conditions of Service and include:—

- (i) any report on a patient not under observation or treatment at the hospital at the time;
- (ii) examinations and reports for prospective emigrants;
- (iii) examinations and reports on candidates for training as teachers;
- (iv) examinations and reports required by employers on employees or prospective employees;
- (v) examinations and reports in connection with legal actions;
- (vi) the "second" certificate of the cremation certificates required by relatives, where the deceased had been under hospital observation or treatment;
- (vii) lectures given by members of hospital medical staffs to nurses, etc., or to the lay public;
- (viii) services performed by members of hospital medical staffs for Government departments as members of medical boards;
- (ix) general practitioner services given by a hospital medical officer under Part IV of the Act to members of the hospital staff who are on his "list".

Amount of such earnings

73. No information is available about the average earnings of practitioners for all the services mentioned in paragraphs 64-72. At 4 guineas each the visits detailed in columns (10) and (11) of the table in paragraph 69 would have attracted the payments shown below. These figures make no allowance for the unknown number of visits made without payment by whole-time practitioners and to this extent the figures tend to be excessive; on the other hand, some of the visits entailed operations and/or use of apparatus and thus attracted payment in excess of 4 guineas and hence tend to increase the figures.

*Fees for domiciliary visits
per practitioner (guineas)*

				<i>Consultant</i>	<i>S.H.M.O.</i>
1950	...	...	...	124	80
1951	...	...	...	128	64
1952	...	...	...	132	48
1953	...	...	...	144	44
1954	...	...	...	160	44
1955	...	...	...	164	48

GENERAL CONDITIONS OF SERVICE

Charges for Board and Lodging

74. As already noted, the Spens Committee's recommendations on the remuneration to be paid to the potential specialists in training were made on the basis that where residential emoluments were received an appropriate sum would be deducted from the salary (Section 9 of the report). Originally

the Terms and Conditions of Service provided that the holders of house officer posts which are resident posts would be charged at the rate of £100 per annum for their board and lodging. Under the agreement for pay increases from 1st April, 1954, this charge was raised to £125 as from the same date and it remains at this rate. Even with the increase the charge is far below the economic cost of the services provided.

75. Residence at the hospital is not generally required of officers above the senior house officer grade though some registrars and a few senior registrars may have to live in. Where such officers were resident, the Terms and Conditions provided until 1956 that the charge for board and lodging should be fixed by the responsible hospital authority equal to the value of the services provided. Under an agreement reached on Committee B of the Medical Whitley Council, this provision was then replaced with effect from 1st August, 1956, by another providing for the charge to be made at a standard rate according to grade. The scale is:—

Senior house officer	... ..	£150 per annum
Junior hospital medical officer	... ..	£170 per annum
Registrar	... ..	£170 per annum
Senior registrar	... ..	£200 per annum
Senior hospital medical officer	... ..	£350 per annum
Consultant	... ..	£400 per annum

It is understood that the agreement was based on the principle that the two senior grades should pay a charge approximating to the cost of the services provided in general and that in the case of the other grades the charge should be lower on the grounds that the officers will not generally have a choice whether or not to reside at the hospital and that the resident is liable to be called upon at any time of the day or night.

The same arrangements have been applied to resident dental staff under agreement between the British Dental Association and the Health Departments.

Expenses

76. The Spens Committee expressed the following views on this subject:—

"Throughout our proceedings we have assumed that specialists engaged either whole-time or part-time in a publicly organised service will be paid any sums which represent expenses necessarily and reasonably incurred in the course of their work, and that these sums will be in addition to the salaries recommended. The Evidence Committee has brought to our notice a number of items of expense which must be met if the specialist is to perform his duties efficiently. These include car expenses; expenses of travel apart from the use of a car; the cost of renewal of instruments and other equipment; the cost of books and journals, preparation of scientific papers, and subscriptions to professional societies; printing, stationery, postage and telephone costs; expenses of attendance at national and international professional meetings; and the expenses of visiting hospitals and clinics at home and abroad and entertaining visiting colleagues.

The expenses might be refunded after they have been incurred, or alternatively an appropriate allowance for expenses might be attached to the various posts held by specialists and consultants. If the latter course were adopted it would have to be realised that certain expenses would arise which had not been foreseen when the allowance was fixed, e.g., attendance at an international conference, and additional provision would have to be made in such cases.

It is presumed that the Inland Revenue authorities would be prepared to consider favourably as legitimate allowances for Income Tax purposes any items of expense which had been approved by a public hospital authority." (Section 16 of the Report).

77. The Terms and Conditions of Service provide that travelling, subsistence and certain other expenses shall be paid to meet actual disbursements. The detailed rules governing the rates and conditions of payment are mostly embodied now in agreements reached on the General Whitley Council for the Health Services (which deals with matters of this sort which are common to all staff employed in the Hospital Services) and adopted by Committee B of the Medical Whitley Council. They are summarised in Appendix H.

Leave

78. In making their report the Spens Committee assumed "that in a publicly organised service the specialist would be entitled to certain definite holidays, and would not be financially liable for providing a deputy". The Committee added that in their view extended leave, apart from normal holidays, would, in the interests of the service, be necessary on occasion for study or research (Section 16 of the report). The Terms and Conditions of Service make provision for paid annual leave, for sick leave and for study leave. The provisions on these matters are summarised in Appendix I.

Age of Retirement

79. On this subject, the Spens Committee adopted the view that there should be a uniform retiring age of 65 for all specialists regardless of the branch of medicine in which they practised (Section 7 of the report).

80. Under the Terms and Conditions the regular contract of a medical or dental officer comes to an end when he reaches age 65. His employing authority has discretion, however:

- (a) to offer him a modified contract (e.g. for a less amount of service); or
- (b) to extend his original contract, where such a course is in their view desirable in the interests of the service.

for a period of up to one year and to renew this arrangement from time to time thereafter until he reaches age 70. A consultant or a senior hospital medical and dental officer who has been filling a post graded as a consultant post, may, on retiring, be given an honorary contract which will permit of his being called in and paid for exceptional consultations and will enable him to treat his private patients in pay-beds (see para. 72).

Superannuation

81. In making their recommendations the Spens Committee assumed that as in private practice in the past specialists would have themselves to provide for insurance against death and old age. They recognised that if their assumption was not correct adjustment would be necessary (Section 16 of the report). In fact hospital medical staff are within the Health Service Superannuation Scheme (to which fuller reference is made in Part V of this memorandum) the cost of the benefits of which is met partly by contributions by the employed persons and partly by the Exchequer, through payments made by the employing authorities. In the case of medical and dental practitioners the value of the contributions made by the employing authorities is 8 per cent. of remuneration (see paragraph 182 below). Accordingly, for a true comparison with the rates of pay recommended by the Committee 8 per cent. needs to be added to the rates of pay which have operated under

the National Health Service. For example, the value of the remuneration (including the value of the Exchequer (employer's) contribution to superannuation) provided under the National Health Service for a consultant as compared with the Committee's recommendation has been as follows:—

	Spens Committee's recommendation	National Health Service Pay and Superannuation Contribution		
		5th July, 1948	1st April, 1954	1st May, 1957
Basic salary	£ 1,500-2,500	£ 1,700-2,750	£ 2,100-3,100	£ 2,205-3,255
Value of Exchequer contribution to superannuation	Assumed practitioner would have to make own provision for insurance.	136-220	168-248	176-260
Total Value ...	1,500-2,500	1,836-2,970	2,268-3,348	2,381-3,515

The figures for a whole-time consultant at the top of the basic salary scale and with a distinction award at the highest rate of £2,500 a year are:—

	Spens Committee's recommendation	5th July, 1948	1st April, 1954	1st May, 1957
	£	£	£	£
Basic salary + distinction award ...	5,000	5,250	5,300	5,455
Value of Exchequer superannuation contribution	Assumed practitioner would have to make own provision for insurance.	420	424	436
Total Value ...	5,000	5,670	5,724	5,891

Any other earnings from work done under the National Health Service, e.g., by way of fees for domiciliary consultations and exceptional consultations are also superannuable and attract an Exchequer contribution of the value of 8 per cent. to the superannuation of the individual.

THE QUESTION OF WHOLE-TIME OR PART-TIME EMPLOYMENT

82. In Section 12 of the National Health Service (Amendment) Act, 1949, there is a statutory prohibition of the introduction of a requirement that all specialists shall be employed whole-time. The fact that part-time employment only would be desired and would be appropriate in some cases has been recognised from the inception of the Service. In a circular sent to hospital authorities in 1948, it was stated:—

"Boards must clearly have regard first to the needs of the service but they should also take into account as far as possible the circumstances and preference of the person concerned. It may, for example, be found that a practitioner who at present devotes part of his time to other medical work wishes to practise exclusively as a specialist, whether whole time or part-time in the service; or that a whole-time

officer wishes in future to give part-time to the service and to engage in private practice. These opportunities should as far as possible be given."

83. Following discussions more recently between the Ministry of Health and the Department of Health for Scotland and the Joint Consultants Committees the following statement was published in the British Medical Journal and the Lancet on 7th May, 1955:—

Consultants and Specialists

Option for whole-time or part-time service

The Joint Consultants Committees have had recent discussions with the Ministry of Health and the Department of Health for Scotland about whole-time and maximum part-time service for consultants in the National Health Service, and the following is an agreed statement of the position:—

It is recognised that some consultants, while prepared to devote substantially the whole of their time to hospital work and to give it priority on all occasions, would prefer a maximum part-time to a whole-time contract. Ever since 1948 it has been the Ministry's view that, subject always to the needs of the hospital service, employing boards should, in this matter, take into account the circumstances and preferences of the consultants concerned. While there has been no previous statement on this point as regards Scotland, the practice in that country has been similar.

Where a new appointment is being made this means that, except where the Board decides that the needs of the hospital service (considered in conjunction with those of the local health services, where the consultant is to undertake duties on behalf of a local authority) demand a whole-time appointment, the competition should be thrown open to all applicants who are prepared to give substantially the whole of their time to the post, whether they prefer a whole-time or a maximum part-time contract. In such a case the successful candidate should not be asked to state his preference until after he has been selected for appointment.

Similarly, if a consultant who is already employed in a whole-time post wishes to transfer to a maximum part-time contract, or vice-versa, the Board should, before reaching a decision, take his circumstances and preferences into account, again subject to the overriding needs of the hospital service.

This statement does not, of course, deal with the many cases where the services of a consultant are needed in the aggregate for only a limited volume of work, and where therefore a part-time appointment would in all cases be appropriate.

84. The Committee on the Cost of the National Health Service considered that under existing conditions there was a valid case for the retention of part-time consultant appointments in addition to whole-time appointments but that the financial arrangements should not be such as to induce a consultant to seek a part-time rather than a whole-time appointment. The Committee's comments on this subject are reproduced in Appendix J.

HOSPITAL SERVICE CAREERS

85. As already explained, all new medical practitioners have now to start their professional life in the Hospital Service. A large proportion, of course, leave sooner or later after attaining full registration to make their careers in other branches of the profession—mostly in general practice. The

practitioner who decides to stay in the Hospital Service will generally need to obtain a higher qualification, such as the M.R.C.P. for a physician, the F.R.C.S. for a surgeon, the M.R.C.O.G. for an obstetrician and gynaecologist and the D.P.M. for a psychiatrist, if he is to stand the best chance of making a satisfactory career and attaining specialist status. The appropriate qualification is usually secured when the practitioner is in the basic registrar grade but it is sometimes obtained before he has reached that grade.

86. In so far as it is possible to generalise—and there are many variations in the pattern of careers—doctors usually follow one or other of two parallel lines of advancement in the hospital service. One—the commoner—leads through the registrar grades to consultant status, the other leads by a route which may include the junior hospital medical officer-grade or the registrar grades to senior hospital medical officer. The two lines are not, however, completely distinct as a good many new senior hospital medical officers are recruited from the senior registrar grade instead of from the registrar grade; and some recruitment to the consultant grade takes place from senior hospital medical officers. The position in the case of dentists is much the same except that there is no dental counterpart to the senior house officer—junior hospital medical officer—senior hospital medical officer sequence.

87. The possibility of progress to the consultant grade being made through the senior hospital medical officer grade is likely to diminish in most specialties; for under an agreement between the Ministry of Health and the profession (which is reproduced in Appendix K) new appointments to the grade of senior hospital medical officer may be made only in certain specialties and for posts carrying limited responsibilities. (Although this agreement does not formally apply to Scotland, practice there is similar.)

88. Most medical students now qualify between 23 and 25 years of age.* Something like one-quarter to a third of those who are due to complete their course this year will be 25 or more on qualification. Figures for a series of years of the ages at which students with a liability to National Service were due to complete their courses of study are given in Appendix L. Allowing for a short gap between qualification and the first house officer appointment and a gap between first and second pre-registration posts, most doctors will be about 26 on completing their pre-registration year.

89. Leaving aside the complication represented by National Service (which many male doctors undertake as soon as the pre-registration year has been done and they have secured full registration), on completing his pre-registration year the doctor will be ready for a third house officer post or a post as senior house officer, which will normally be held for one year. If he stays in the hospital service his next step will be to an appointment as a registrar or a junior hospital medical officer. For a doctor who qualifies at 24 years of age and holds only one post in each of the various training grades, progress to an appointment as a senior hospital medical officer or consultant will follow one of the patterns shown in the statement on the facing page.

90. As already mentioned, however, many practitioners in fact hold more than one post in the time-limited grades. Moreover, some practitioners are holding appointments in the senior registrar grade for more than four years (though conversely some are spending less than four years in the grade before obtaining higher appointments).

91. The ages of the practitioners who secured the higher appointments made in England and Wales in the years 1954 to 1956 were as shown in the table on page 28.

* In the case of dental students qualification is usually obtained between 22 and 24 years of age.

Senior house officer—registrars grades—consultant			Senior house officer—registrars—senior hospital medical officer. (Note 3)			Senior house officer—junior hospital medical officer—senior hospital medical officer		
Grade	Age	Whole-time Salary	Grade	Age	Whole-time salary	Grade	Age	Whole-time salary
Senior house officer (one-year post)	26	£ 820	Senior house officer	26	£ 820	Senior house officer	26	£ 820
Registrar	27	935	Registrar	27	935	Junior hospital medical officer	27	853
Registrar (two-year post)	28	1,062	Registrar	28	1,062		28	908
Senior registrar	29	1,210	Senior hospital medical officer	29	1,549		29	963
Senior registrar (four-year post)	30	1,320		30	1,549		30	1,018
	31	1,430		31	1,601		31	1,073
	32	1,540		32	1,654		32	1,128
	33	2,205		33	1,706		33	1,183
Consultant	34	2,336		34	1,759			(maximum of scale)
	35	2,468		35	1,811			
	36	2,599		36	1,864			
	37	2,730		37	1,916			
	38	2,861		38	1,969			
	39	2,993		39	2,021			
	40	3,124		40	2,074			
	41	3,255		41	2,126			
		(maximum of scale, excluding distinction awards)			(maximum of scale)			

The tenure of a junior hospital medical officer post is not necessarily limited but in some cases such a post is of limited tenure and is intended as a training post for an appointment as senior hospital medical officer which in such cases is normally obtained well before the maximum of the junior hospital medical officer scale is reached.

Notes:

- (1) Where the annual remuneration under current salary scales includes shillings the amounts have been rounded up or down to the nearest £.
- (2) Where an appointment as consultant, senior hospital medical officer or senior hospital dental officer is obtained after the age of 32, the employing authority has discretion to give a starting salary up to four points above the normal minimum for an appointee age 32 or more on the grounds of age, experience and qualifications, provided the appointee is not given a higher salary than he would have been entitled to if he had entered the scale when he was 32. Accordingly, though in the first career pattern given the doctor would not reach the consultant grade until the age of 33, he might then be given a starting salary of £2,336 instead of £2,205, and in this event he would reach the maximum of £3,255 (excluding distinction awards) at the age of 40.
- (3) Sometimes a post in the Senior Registrar grade is held before a post as senior hospital medical officer is secured. Information before the Ministry of Health suggests that out of about 200 new appointments to the senior hospital medical grade in each of the past three years 60-70 have come from the Senior Registrar grade.

AGES OF PRACTITIONERS SECURING HIGHER APPOINTMENTS

Age on appointment	Medicine						Dentistry					
	Consultants			Senior hospital medical officers			Consultants			Senior hospital dental officers		
	No. of appointments made in:			No. of appointments made in:			No. of appointments made in:			No. of appointments made in:		
	1954	1955	1956	1953/1954	1954/1955	1955/1956	1954	1955	1956	1953/1954	1954/1955	1955/1956
27/28 ...				3	3	1						1
28/29 ...				5	6	2				1		2
29/30 ...	2		1	10	7	2					2	
30/31 ...	4	2	2	11	17	10					1	1
31/32 ...	12	7	1	16	13	15	1			1	1	
32/33 ...	18	15	7	15	17	16					1	1
33/34 ...	23	22	20	14	15	13				3	1	2
34/35 ...	28	26	32	13	17	20	1				1	
35/36 ...	22	34	32	15	14	15			1	3		
36/37 ...	31	32	21	9	10	9	1		2		1	
37/38 ...	20	26	20	17	11	11	1	1			2	1
38/39 ...	23	35	11	12	13	11	1		2			
39/40 ...	18	15	13	8	8	8				1	1	1
40/41 ...	13	13	7	9	10	9		1	1	1		1
41/42 ...	7	12	13	9	6	12	2	1	2	2		1
42/43 ...	5	14	10	4	7	2	1					
43/44 ...	6	5	7	5	8	2		1				
44/45 ...	4	4	4	1	4	2						
45/46 ...	2	5	4	3	4	5			1			1
46/47 ...	1		4	4	6	4						
47/48 ...	1	2	3	6	1	2						
48/49 ...	3	2	2	1	2	1						
49/50 ...	1	2	4	2	3	1					1	
50/51 ...	6	1	1	4	1	2				1		
51/52 ...	1				1	2				1		
52/53 ...	5	1	1	2	1	4				1		
53/54 ...	1			3	1	3			1			
54/55 ...			2		1	5					1	
55/56 ...	1		1	3	5	2				1		1
56/57 ...		1	1			1						
57/58 or over	2	2	2	4	1	10				1		
Totals ...	260	278	226	208	213	202	8	4	10	17	13	14

Consultant figures relate to calendar year; Senior Hospital Medical Officer figures to years ending 30th June.

92. Career prospects depend upon how many posts are going to be available and how keen the competition for them is likely to be. Fairly detailed information on the foreseeable aspects of these matters is available and is set out in the following paragraphs.

93. The number of posts that will be available depends mainly upon (a) loss through retirements and deaths (b) expansion. The latter factor in relation to doctors comes within the terms of reference of the Committee which is sitting

under the chairmanship of the Rt. Hon. Henry Willink to which reference has already been made. The position in relation to the dental profession in general is dealt with in the report of the McNair Committee to which reference has also already been made.

94. With regard to factor (a), the age distribution of the practitioners in the two senior grades in medicine and dentistry in England and Wales at 30th June, 1956, was as follows:—

Age* Group	Medicine				Dentistry			
	Consultants		S.H.M.Os.		Consultants		S.H.D.Os.	
	Number	Per cent.	Number	Per cent.	Number	Per cent.	Number	Per cent.
Under 35 ...	140	2.2	180	7.8	2	0.8	15	6.6
35-39 ...	977	15.2	383	16.6	15	6.0	27	11.8
40-44 ...	1,553	24.1	459	19.9	55	21.9	42	18.3
45-49 ...	1,259	19.5	379	16.4	51	20.3	36	15.7
50-54 ...	1,058	16.4	327	14.2	44	17.5	44	19.2
55-59 ...	921	14.3	368	16.0	31	12.4	40	17.5
60-64 ...	453	7.0	175	7.6	39	15.5	24	10.5
65 or over ...	83	1.3	34	1.5	14	5.6	1	0.4
Totals ...	6,444	100	2,305	100	251	100	229	100

NOTE:—Practitioners who have retired but been given an honorary appointment on retirement are not included; but practitioners who hold honorary appointments in association with a teaching appointment or a research appointment are included. Practitioners practising in more than one speciality are counted once only.

* The age grouping of each individual was based on the year of birth and not on actual date of birth.

95. The age distribution of consultants in some of the individual medical specialities differs appreciably from that for all specialities. The number of sessions worked by a part-time practitioner may also be a factor, since where the number is small these sessions may be secured, on the practitioner's retirement, by another part-time practitioner and a new appointment to the grade may not be made. Thus competition for a vacant post may come from within the grade itself as well as from a lower grade. Appendix M shows the age distribution of these senior grades by speciality and the number of sessions worked by those in each of the age groups.

96. The degree of competition for consultant posts depends principally upon the number of practitioners in the recognised training grade for consultant posts, i.e., the senior registrar grade. In 1951, the number of posts in this grade was brought under the direct control of the two central Health Departments because it had grown to a figure greatly in excess of foreseeable vacancies in the consultant grade. A certain number of posts in the various specialities was approved for the teaching and non-teaching hospitals in each Region. Since this happened the number of senior registrars has fallen—as will be seen from Appendix A—and at 30th June, 1956, it was as follows:—

	Medicine	Dentistry
Holders of 1st year posts ...	328	7
Holders of 2nd year posts ...	291	8
Holders of 3rd year posts ...	209	6
Holders of 4th year posts ...	153	7
Others ...	314	22
Total	1,295	50

The total number of approved training posts at the same date was 1,229. The distribution of these posts between the various specialties and the actual number of senior registrars employed in each specialty, is shown in Appendix N. (Sheets 1 and 2.)

97. Notwithstanding the fall in numbers since the early years of the National Health Service, the senior registrars employed still exceed the approved number of training posts. Some excess over the number of foreseeable vacancies is necessary if the service is to be assured that the candidates for the higher appointments will normally have spent the proper term in training and that there will be real competition for the vacancies: there will always be the exceptionally gifted people who will be ready for consultant posts in less than the normal time, but it is not to be expected that these will be common. Moreover, the excess shown by the figures is not altogether a real one. It includes a substantial number of university teachers and of research workers with honorary hospital appointments as senior registrars; an appreciable number of practitioners who are holding part-time appointments in the grade and who in most cases are holding part-time appointments in a higher grade at the same time; and some practitioners who by virtue of being in permanent appointments of similar status before the inception of the National Health Service in July, 1948, have been given appointments in the senior registrar grade without the normal limit of tenure. Taking due account of those factors, however, there is an excess in some specialties of senior registrars who have long completed their four years of training and have been seeking a higher appointment but have so far failed to obtain one. Appendix O shows for the senior registrars in England and Wales who were in this position at the end of June, 1956, the years in which they qualified. The appointments of the senior registrars in this position are at present being continued on a year by year basis so that they may have more time to compete for higher appointments. In order to avoid building up a bigger surplus again hospital authorities have been asked, however, not to make new appointments except when an existing appointment becomes vacant. Consequently those senior registrars who are looking for higher appointments are to some extent blocking posts which are intended for training and thus limiting the intake of new trainees. The real excess is most marked in the specialties in which in pursuance of the agreement referred to in paragraph 87 above the only permanent appointments now being made above the senior registrar grade are in the grade of consultant.

98. In the discussions which are proceeding between the Health Departments and the Joint Consultants Committee on the junior medical staffing structure in the hospital service consideration is being given to the problem presented by the excess of fully trained senior registrars.

REGIONAL HOSPITAL BOARDS' HEADQUARTERS' STAFF

99. Regional Hospital Boards' administrative medical staff consists of the following:—

	<i>England & Wales</i>	<i>Scotland</i>
Senior Administrative Medical Officers ...	14	5
Deputy Senior Administrative Medical Officers	14	1
Assistant Senior Medical Officers	23	5
Medical Officers	—	6
Regional Psychiatrists	8	—
(in some cases these officers are part-time)	—	—
Total	59	17

100. The need for the appointment of some administrative medical staff arose before the Spens Report on Consultants and Specialists had been made and before the Whitley Councils for the Health Services were set up and initially the rates of pay were laid down by the Minister of Health and the Secretary of State for Scotland. The British Medical Association were told at the time that the salaries were provisional and would be reviewed in the light of the Spens Report when received and other relevant salaries.

101. In 1950, the Staff Side of Committee B of the Medical Whitley Council brought forward a claim for higher salaries. Negotiations broke down and the difference was referred to the Industrial Court. The salaries awarded by the Court* were subsequently embodied in an agreement on Committee B which also included revised salaries for Assistant Senior Medical Officers and Medical Officers, grades which were not brought into the proceedings before the Court. A revision of the salaries of all grades was agreed upon Committee B in 1955.

Appendix P gives the original salaries, the salaries agreed following the Industrial Court's award and the salaries agreed in 1955 which are still current.

PART III: GENERAL MEDICAL SERVICES

Introductory

102. Section 33 of the National Health Service Act, 1946, and Section 34 of the National Health Service (Scotland) Act, 1947, place a duty upon Executive Councils to make arrangements with medical practitioners for the provision of personal medical services for all persons in their areas who wish to take advantage of the arrangements, which the Acts call "general medical services". Power is also given to the Minister and the Secretary of State for Scotland by regulations to make provisions for defining the personal medical services to be provided and for securing that the arrangements are such that all persons availing themselves of the services receive adequate personal care and attendance. The regulations made under this power are incorporated in the National Health Service (General Medical and Pharmaceutical Services) Regulations, 1954 as amended, and the National Health Service (General Medical and Pharmaceutical Services) (Scotland) Regulations, 1955 as amended. The persons for whose treatment responsibility rests upon a practitioner with whom an Executive Council has made arrangements, the range of service to be provided and the duties of such a practitioner are defined in the Terms of Service for Medical Practitioners which form Part I of the First Schedule to these Regulations. A detailed description of the scope of General Medical Services and of the arrangements relating to them is given in the Handbooks for General Medical Practitioners published by the Ministry of Health and the Department of Health for Scotland.

103. By the Terms of Service the practitioner is responsible for the treatment of all persons whom he has accepted for inclusion on his medical list, and certain other classes of persons referred to in paragraph 3 of the Terms of Service. He is required to render all proper and necessary treatment within the range of service defined in paragraph 6 of the Terms of Service. Maternity medical services are the subject of a separate arrangement with the patient.

* The Court's award, which summarises the cases present by the two Sides of Committee B is published (The Industrial Court (2322) National Health Service).

104. The duties of the practitioner are set out in paragraph 7 of the Terms of Service, and include attending during surgery hours, providing surgery and waiting room accommodation, visiting and treating patients, issuing certain specified medical certificates, prescribing (and in certain cases supplying) drugs and appliances, referring the patient to the hospital and specialist services or the local authority services where necessary, and keeping records.

105. Generally speaking, the practitioner is not allowed to receive fees from patients taking advantage of the General Medical Services except for items of service not covered by the Terms of Service, e.g., the issue of certain medical certificates. He is at liberty, if he wishes, to undertake other work, including treatment of private patients, and entering into such other employment or contracts as factory doctor, medical referee to an Insurance Company, civilian medical practitioner under the Admiralty, War Office or Air Ministry, or member of the staff of a hospital, clinic, or nursing home. The practitioner remains responsible for the expenses incurred in connection with his practice.

106. In return for providing these General Medical Services, the practitioner is entitled to the payments referred to in Part II (Remuneration of Practitioners) of the First Schedule to the Regulations of 1954 and 1955.

107. Most of these payments are found from a Central Pool for the whole of Great Britain. Further reference to the Central Pool is made in paragraphs 115, 123-126, and 130-135.

Method of entry into general practice as a principal

108. A doctor may enter general practice as a principal in one of three ways :—

- (a) He may apply to succeed to a vacancy in a single-handed practice resulting from death or retirement. About one-sixth of new principals enter practice this way. Except where the practice is very small or in a remote and unattractive district, competition for vacancies of this kind is severe. In 1955, the average number of applicants for a vacant practice was 44 : only one vacancy attracted fewer than ten applications, while for five there were over 100 and for two there were 150. There is a continuing preference among applicants for the South of England in spite of easier entry into practice in the industrial areas of the North. In Scotland the competition for vacancies appears to be slightly less acute than in England and Wales; in a sample of 20 vacancies in 1955 the average number of applicants was 34.
- (b) He may apply, through the Executive Council to the Medical Practices Committee,* to start a new practice of his own, and his application will be allowed unless the Medical Practices Committee are satisfied that the number of doctors in the area concerned is already adequate. About one-sixth of new principals enter practice this way. There are two Medical Practices Committees—one for England and Wales and one for Scotland.
- (c) Where a vacancy occurs or is about to occur in an established partnership through retirement or death, or a single-handed doctor wishes to create a partnership, an "assistant with a view" is normally engaged and after a trial period he will, if suitable, be taken into partnership. This is now the method of choice for the young doctor and about two thirds of new principals enter practice this way.

* The functions of the Medical Practices Committee are set out in paragraph 24 of the "Handbook for General Medical Practitioners" issued by the Ministry of Health and paragraph A.28 of the corresponding hand book issued by the Department of Health for Scotland.

The number and proportion of National Health Service general practitioners in partnership have increased steadily since 1953, when changes favouring partnerships were made in the method of distributing the Central Pool (see paragraph 127).

109. Doctors entering general practice are thus able to practise where they choose, subject only to the restriction applied by the Medical Practices Committee in adequately doctored areas—and even this is not applied where a vacancy in an existing partnership is being filled. The areas into which the Medical Practices Committee (England and Wales) at present restricts the entry of further doctors cover a patient-population of not much more than two million (July, 1956). The Scottish Committee does not maintain a list of restricted areas but deals with each application on its particular circumstances; in only one or two areas are applications consistently refused.

110. It is no longer necessary—indeed it is illegal in the National Health Service—for a doctor to purchase a practice. He may have to buy the practice premises from his predecessor, but in such a case he can ask the Medical Practices Committee to certify that the transaction involves no sale of goodwill. A general practitioner has almost complete security of tenure. Once he has been admitted to the medical list, he is at liberty to remain on it until his retirement, for which there is no age limit. His name can be removed from the list contrary to his will only if he has never provided or has ceased to provide services, or if a case has been successfully made to the Tribunal, under Section 42 of the Act of 1946 or Section 43 of the 1947 Act, that his continued inclusion in the list "will be prejudicial to the efficiency of the services in question". It is only very rare and serious cases which come before the Tribunal and if this body does decide on removal from the list, the practitioner has a further right of appeal to the Minister or Secretary of State though there is no appeal against a Tribunal decision in his favour.

Numbers of Doctors providing General Medical Services

111. The number of doctors providing General Medical Services in mid-1956 was 22,551. It has increased year by year from the inception of the National Health Service and its growth has been proportionately greater than the growth in the total population. The comparisons between 1952 and 1956 are as follows:—

	1.7.52	1.7.56
Practitioners practising as Principals (other than those with limited lists or liabilities—see next item)	19,645	21,703
Practitioners practising as Principals with limited lists, i.e., with lists confined to hospital staffs or to pupils and staff resident in schools, or who have been relieved of certain responsibilities, e.g., the liability to have persons assigned to them or to undertake emergency night calls to persons not on their lists	872	783
Practitioners practising as Principals but providing Maternity Medical Services only ...	71	65
Total	20,588	22,551
Percentage Increase 1956 over 1952		9.6
Population (in 1,000's)	49,003	49,784
Percentage Increase 1956 over 1952		1.5

112. Information about the number of doctors providing General Medical Services at 1st July in each of the last five years is given in more detail in Appendix Q.

Size of lists of principals in different age-groups

113. General practitioners are classified according to age-group and size of list in Appendix R attached.

Payments made to Doctors in connection with the provision of General Medical Services

114. The total sums paid to general medical practitioners in connection with the provision of General Medical Services in each of the last five financial years for which information is available have been:—

	1951/52	1952/53	1953/54	1954/55	1955/56
	£ million	£ million	£ million	£ million	£ million
England and Wales	41·622	74·012*	50·945	51·762	54·074
Scotland	5·219	8·989*	6·319	6·432	6·715
Totals	46·841	83·001	57·264	58·194	60·789

These figures do not include the value of the Exchequer contribution to the National Health Service Superannuation Scheme which in 1955-56 amounted to £2·971 million. Moreover they do not include the payments for sight-testing under the Supplementary Ophthalmic Services (see paragraphs 142-144) made to general practitioners providing general medical services; in 1955-56 these payments amounted to £94,000.

115. The components of the total sums paid in 1955-56 were:—

	England and Wales	Scotland
	£ million	£ million
(a) Capitation payments	36·693	4·226
(b) Loadings	8·610	1·103
(c) Payments in respect of temporary residents	0·770	0·104
(d) Payments for emergency treatments	0·002	0·008
(e) Payments for administration of anaesthetics	0·003	
(f) Initial practice allowances	0·075	0·008
(g) Hardship payments to elderly doctors and to doctors with small lists ...	0·003	0·001
(h) Supplementary annual payments ...	0·096	0·008
(i) Payments from the Mileage Fund ...	1·551	0·447
(j) Group practice loans (less repayments)	0·141	0·015
(k) Special inducement payments ...	0·013	0·030
(l) Payments for maternity medical services	2·555	0·384
(m) Grants for training assistants ...	0·331	0·103
(n) Central Pool balances (in respect of 1952-53 and 1953-54)	1·324	0·156

* Includes Danckwerts arrears 1948/49 to 1951/53.

(o) Supply and dispensing of drugs and appliances (including payments by patients)	1.738	0.114
(p) Contributions under Regulation 46 (3) (n) of the Superannuation Regulations, 1950, and Regulations 76 of the Superannuation Regulations, 1955	0.169	0.008
Total	54.074	6.715

Payments (a) to (j) inclusive and (n) are made out of the Central Pool.

116. Explanations of the purposes of the above payments are given below:—

- (a) A capitation payment of 17s. (17s. 6d. from 1st May, 1957) is paid in respect of each patient on a practitioner's list up to the permitted maxima (see paragraph 127).
- (b) An additional "loading" payment of 10s. (11s. 6d. from 1st May, 1957) is made for each listed patient in excess of 500 up to 1,500 (see paragraph 127).
- (c) Payments of 17s. are paid in respect of treatment given to persons not on the practitioner's list but temporarily resident in the locality. For patients treated in convalescent homes and in other similar institutions where the practitioner's patients may be collected together the payment is 8s. 6d.
- (d) If a practitioner provides emergency treatment for a patient not on his list or the list of a partner he can seek payment as set out below. (In most areas the doctors have agreed amongst themselves not to claim these fees.)

Emergency consultation	8s. 6d.
Minor surgical operation	15s. 0d.
Administration of general anaesthetic	35s. 0d.

- (e) Where a practitioner has to provide the services of a second practitioner to give a general anaesthetic the first practitioner can claim a fee of 15s. or 35s. according to the type of anaesthetic.
- (f) Initial practice allowances are paid, under certain conditions, to assist doctors who are setting up new single-handed practices in areas designated by the Medical Practices Committee as needing more doctors. In such areas an allowance is sometimes given to a doctor filling a vacancy in a small single-handed practice the continuance of which is considered necessary by the Committee. Allowances are paid for a maximum of three years and are set out below. As part of the interim settlement mentioned in paragraph 129 these allowances are to be increased by 25 per cent but details have still to be worked out.

First year —£600.

Second year—the amount required to raise the practice income to a gross total of £1,000 subject to a maximum of £450.

Third year —the amount required to raise the practice income to a gross total of £1,100 subject to a maximum of £200.

- (g) Hardship payments up to £350 per annum are made in cases of hardship, chiefly amongst elderly doctors, where hardship arose in consequence of the introduction of a new method of remuneration in 1953 (see paragraph 127). Generally hardship payments have been superseded by Supplementary Annual Payments (q.v.). It has been agreed, as part of the interim settlement mentioned in paragraph 129, that hardship payments should be increased by 25 per cent.
- (h) Supplementary annual payments (up to £350 per annum are made to certain doctors on account of age and the small sizes of their practices. This scheme of payments supersedes the hardship payments schemes, but hardship payments are continued to a few doctors to whom they are more advantageous. It has been agreed, as part of the interim settlement mentioned in paragraph 129, that supplementary annual payments should be increased by 20 per cent.
- (i) Mileage is paid to doctors treating persons in rural areas entailing journeys more than two miles from the doctors' residences or where travelling presents exceptional difficulty. The system of mileage payments is under review.
- (j) Group Practice loans (free of interest) are intended to stimulate the formation of group practices and are given for the erection of new premises, the acquisition of existing buildings and their conversion into surgeries.
- (k) Inducement payments are made to doctors in areas sparsely populated or otherwise unattractive and which yield by way of ordinary remuneration too little to ensure the maintenance of a satisfactory medical service. These payments are under review.
- (l) Doctors providing maternity services for patients on their lists are entitled to certain payments for maternity services (see paragraphs 136-138).
- (m) Grants are made to a limited number of doctors for the training of assistants. The grants are £150 per annum plus an allowance for the salary and boarding expenses of the trainee, not exceeding £775 per annum (£850 from 1st May, 1957) plus a car allowance of not more than £150 per annum if an additional car is necessary. (An increase in the car allowance is under consideration.)
- (n) After the payments from the Central Pool have been made any balance remaining in the Pool at the end of the financial year is distributed to doctors proportionately to their earnings by way of capitation fees and loadings (see paragraph 133).
- (o) (i) For drugs and dressings (other than any specially expensive items which are set out in a list known as the Special List) which may be required for immediate administration or use before a supply can be otherwise obtained, doctors receive a payment of 2s. 6d. per annum per 100 patients other than dispensing patients (see (ii) below). Separate payment on priced costs may be claimed for items on the Special List for drugs supplied and administered personally and for certain types of pessary supplied.

In Scotland, in place of this capitation payment, there is a system whereby a stock of drugs and dressings required for immediate administration or use may be ordered from the chemist by the doctor on a N.H.S. form. The chemist supplies the doctor free of charge and is paid by the Executive Council.

(ii) 2,708 general practitioners dispense for some or all of their patients. This arrangement applies only in rural areas where the patient would have serious difficulty in reaching a chemist or lives more than one mile from the nearest chemist and where either the doctor agrees to dispense or the Executive Council directs that he shall do so. 2,191 of these doctors are paid a capitation fee of 9s. 9d. per dispensing patient per annum plus the priced cost of any Special List preparations. They may also claim the priced cost of other expensive preparations and of preparations irrespective of price shown to be needed by any one patient over a period of three months or more. The remaining 517 doctors are paid the priced cost of each prescription given. The doctors concerned may choose the basis on which they are paid. Dispensing doctors are required to collect the patients' charges of one shilling per prescription (10s. or 5s. if elastic hosiery is supplied) and to remit the charges collected to the Executive Council.

Where, under (i) or (ii) the items supplied are priced individually the basis of payment is that used for chemists for the prescriptions they dispense, i.e., the net ingredient cost of the item as laid down in the Drug Tariff prepared under Regulation 27 of the National Health Service (General Medical and Pharmaceutical Services) Regulations, 1954; plus 25 per cent of this sum as an overhead on-cost plus a dispensing fee (the average fee is about 1s. 2½d.) plus a container allowance of 1-55d.

The total number of dispensing doctors in Scotland is 173: of these 140 are paid for dispensing on a capitation fee basis, and 33 on the drug tariff basis. The Scottish average dispensing fee is 1s. 8d. The Scottish container allowance is at present 2d. per prescription.

- (p) When a practitioner had elected, at the inception of the National Health Service, to remain outside the National Health Service Superannuation Scheme and to continue to hold a contract or policy of insurance with a Life Assurance Company, the Minister pays to that practitioner a contribution towards the maintenance of the contract or policy an amount equal to 8 per cent of his net remuneration (i.e., from payments reduced by an agreed formula to cover practice expenses).

Remuneration

The Spens Committee

117. In 1945, a Committee—the first of the three Spens Committees—was appointed to consider “what ought to be the range of total professional income of a registered medical practitioner in any publicly organised service of general medical practice; to consider this with due regard to what have been the normal financial expectations of general medical practice in the past, and to the desirability of maintaining in the future the proper social and economic status of general medical practice and its power to attract a suitable type of recruit to the profession”.

118. The evidence placed before the Committee on behalf of the profession included information about general medical practitioners' incomes in 1936-1938. Commenting on an analysis of incomes in urban areas in those years after deducting professional expenses allowed for purposes of income tax, the Committee said in their report:—*

* Report of the Inter-departmental Committee on Remuneration of General Practitioners (Cmd. 6810).

"Having regard to length of training, to the arduousness of the general practitioner's life compared with that in other professions, to the greater danger to health, to the skill and other qualities required and to the degree of individual responsibility, we are unanimous in holding that the percentages of low incomes are too high. Having regard to the same facts, we are clear also that the proportion of practitioners able to reach a net income of £1,300 or over is too low. We consider that unless conditions are substantially improved in both these respects, and on the basis of a pre-war value of money, the social and economic status and the recruitment of general medical practice would not, in the long run, be maintained. We believe that this would be so even apart from proposals for a publicly organised general medical service. There is, however, one particular factor involved in comprehensive proposals for such a service which is calculated to have very grave repercussions on recruitment to general practice unless the financial expectations in that field of practice are improved. In the past, many young doctors have been deterred from becoming specialists by the considerable risks and by the practical certainty of a number of lean years if they attempted to do so. In a comprehensive public service it is inevitable and right that the risks and lean years will present a less formidable deterrent. A much increased menace to the recruitment of general practitioners in the future will lie, in our judgment, in the competition of other branches of medicine than general practice. We, and not least our lay members, consider that it would be disastrous to the profession and to the public if general practice were recruited only from the less able young doctors. We consider, however, that unless the financial expectations in general practice are substantially improved the great majority of the abler men will seek to become specialists, in view of the fact that as specialists they have an equal outlet for their interests in medicine, can more easily keep close contact with hospitals and with medical progress and will have a less arduous life.

There is a further factor to which we attach considerable importance. The help, support and comfort, which a doctor can give to his patients must, in our judgment, be seriously affected if a doctor is himself seriously worried. We have no doubt that low incomes have, in fact, been a source of grave worry to many general practitioners and must have prejudiced their efficiency." (Paragraph 8.)

119. The Committee summarised their recommendations as follows:—

"(1) A scheme should be devised which will ensure that between 40 and 50 years of age approximately 50 per cent of general practitioners receive net incomes of £1,300 or over, and which will also secure, so far as practicable, that between 40 and 50 years of age approximately three-quarters receive net incomes over £1,000, that approximately one-quarter receive net incomes over £1,600, that slightly less than 10 per cent receive net incomes over £2,000 and that, in a small proportion of cases, it is possible to obtain net incomes of at least £2,500. By net income we mean gross income less such professional expenses as are allowed by the Inland Revenue for Income Tax purposes. Here also, as in the body of the report, we are expressing our recommendations in terms of the 1939 value of money.

Note (i).—The above proposal is approximately equivalent to the augmentation of net incomes in 1939 by £200 in the case of incomes between £400 and £1,200 and, in the case of incomes over £1,200 by £200 at £1,200, diminishing progressively to nothing at £2,000.

Note (ii).—We say nothing about reducing the high percentage of incomes below £700 since this would follow automatically from the operation of these recommendations.

(2) Before 40 and after 50, practitioners should be remunerated at the rate applicable between 40 and 50 to the burden and responsibilities of practice which they are in fact carrying.

(3) In securing the above results, a method of differentiation of income should be chosen which will command so far as possible the confidence of the profession.

(4) The difference which has existed between the incomes of rural and urban practitioners should be reduced, the Highlands and Islands Scheme should be applied to other sparsely populated areas and the remuneration under that scheme should be increased.

(5) Additional remuneration should be given in areas which prove so unattractive as not to draw an adequate supply of practitioners.

(6) An adjustment in the method of payment in so far as this depends on capitation should be made in the case of practices involving an altogether abnormal number of aged persons and chronic invalids.

(7) On completion of resident hospital appointments a recently qualified practitioner should secure an initial net income of not less than £500 per annum, as an assistant to a doctor in general practice."

With regard to the statement that recommendations were being expressed in terms of the 1939 value of money, the Committee stated in the body of the Report (paragraph 6):—

"At an early stage in our deliberations we reached the conclusion that we were not qualified as a Committee to form an opinion on what adjustment of immediately pre-war incomes was necessary to produce corresponding incomes today, and that the best course for us to pursue was to consider what incomes would have been satisfactory, for the purposes with which we are concerned, in terms of the 1939 value of money. Throughout this report, our recommendations are, therefore, these which it appears to us would have been necessary for the purposes of our remit had we been reporting in 1939. We leave to others the problems of the necessary adjustment to present conditions, but we would observe in this connection that such adjustment should have direct regard not only to estimates of the change in the value of money but to the increases which have in fact taken place since 1939 in incomes in other professions. In our judgment, it is only if corresponding changes are made in the incomes of general practitioners that the recruitment and status of their profession will be maintained as against these professions."

120. The report was received at a time when the remuneration for the provision of medical benefit under the old National Health Insurance Scheme was under discussion and the Minister's attitude to the report was expressed as follows in a letter addressed to the British Medical Association in July, 1946:—

"The principal factor in any consideration of this question [i.e., remuneration under the National Health Insurance Scheme] and of the question of remuneration in the future Health Service is the report of the Spens Committee on the Remuneration of General Practitioners. The Minister desires to make his attitude to that report quite clear. He fully accepts the substance of the recommendations of the Committee in their majority report upon the general scope and range of remuneration which general practitioners should enjoy in a public service. The actual

terms of remuneration cannot, however, be calculated from the recommendations by a simple process of arithmetic; the calculation involves consideration of a number of factors (e.g., the effect of a superannuation scheme and the percentage of betterment to be applied to pre-war figures) which are matters for discussion."

121. The Committee's recommendations represented an augmentation of net remuneration in pre-war values. In the discussions between the Ministry and the profession following the submission of the report, the statistical advisers to the two parties agreed that to give effect to the recommendations the average net remuneration of general medical practitioners would need to be increased by £173 per annum—also in pre-war money values.

122. The advisers further agreed that 17,900 general medical practitioners were concerned, and that the following figures should be accepted as the basis of calculating remuneration in the National Health Service:—

Total pre-war gross incomes	...	...	...	£28·14	million
Total pre-war practice expenses	...	...	...	£11·35	"
Total pre-war net income	...	...	...	£16·79	"
Spens addition ($£17,900 \times £173$)	...	...	...	£3·10	"
Total pre-war net incomes (including Spens addition)	...	...	...	£19·89	"

The Danckwerts Adjudication on the Size of the Central Pool

123. Negotiations on the level of remuneration to be provided in the National Health Service were conducted directly between the Health Departments and the General Medical Services Committee of the British Medical Association. Though when the Medical Whitley Council was established provision was made for there to be a Committee (Committee A) of the Council to deal with the remuneration of Medical practitioners providing general medical services—see paragraph 4 of Appendix C—by agreement negotiations have continued to be carried on between the Departments and the General Medical Services Committee and Committee A of the Whitley Council has never functioned.

124. Differences arose between the Department and the Committee over the adjustment of the Spens recommendations "to present conditions" and on the question whether the Central Pool should be increased in accordance with the growing number of practitioners providing General Medical Services. Eventually it was agreed that the differences should be referred to adjudication. Both parties agreed in advance to accept the award of the adjudicator, subject to the overriding authority of Parliament and to a satisfactory scheme of distribution of the Central Pool being worked out. The adjudicator's terms of reference were agreed as follows:—

"To determine the size of the Central Pool, after taking account of remuneration from all other sources received by general practitioners, in order to give effect to the recommendations of the Spens Committee, having regard to the change in the value of money which has taken place since 1939, to the increases which have taken place in the income in other professions and to all other relevant factors."

At the same time that the terms of reference were agreed, agreement was reached by the parties on the following other matters:—

- (1) A Working Party composed of representatives of the General Medical Services Committee of the British Medical Association and officers of the Ministry of Health would be set up with the following terms of reference:—

"To secure an equitable distribution of the Central Pool based upon the recommendations of the Spens Committee, the object being to enable the best possible medical service to be available to the public, and to safeguard the standard of medical service by discouraging unduly large lists; at the same time to bring about a relative improvement in the position of those practitioners least favourably placed under the present plan of distribution, to make it easier for new doctors to enter practice and to stimulate group practice."

- (2) Although every effort would be made to reach agreement within the Working Party, arbitration on any fundamental points of disagreement was not ruled out. Any new proposals on a scheme of distribution would be referred by the profession's representatives to a Conference of representatives of Local Medical Committees before any final decisions were given.
- (3) The adjudicator's award would be made known without waiting for the Working Party's report.
- (4) Following an award on the basis of data available at the time, practice expenses might thereafter be the subject of regular periodical review so that the allowance in respect of them might be adjusted in either direction, as might be found appropriate.
- (5) The adjudicator's terms of reference did not prevent him, if he thought fit, from expressing an opinion on the effect which a variation in the number of doctors in the Service would have on the Central Pool.

Mr. Justice Danckwerts agreed to act as adjudicator and the hearing took place in March, 1952.

125. The adjudicator's award, which was given in the same month, was as follows:—

"My determination is that the size of the Central Pool for the year ending on the 31st March, 1951, should be £51·252 millions. As was agreed at the hearing, an adjustment to this figure will have to be made in respect of Exchequer superannuation contributions. In order that this determination may be applied to other years, I add the following explanations:—

- (1) I have applied a betterment factor of 100 per cent to the figure of £19·89 millions for 1939. In my view, the corresponding factor in 1948 would be 85 per cent.
- (2) The figure which I have reached has been adjusted by reference to the number of doctors in the National Health Service and not the population. There was no evidence before me that an unnecessarily large number of doctors is likely to enter the Service within the next few years but if the number of doctors in the Service became unreasonably large this point would require reconsideration.
- (3) I have excluded interest on compensation moneys from consideration.
- (4) I have excluded from the credits which had to be deducted in determining the size of the Central Pool the amount of the Inducement Fund in respect of unattractive areas.
- (5) I have taken a percentage of 38·7 per cent for expenses. But I have not accepted entirely the figures to which this percentage should be applied."

For the further assistance of the parties in applying the award to years other than 1950-51, the adjudicator authorised them to be provided with the following additional information:—

- (1) The Adjudicator used the number 19227 in adjusting the figure reached by reference to the number of doctors.
- (2) The adjudicator adopted the figures below set out as representing the 1950-51 payments from the sources indicated:—
 - (i) £1·100m. Part II payments (i.e. payments by hospital authorities).
 - (ii) 400m. Part III payments (i.e. payments by local authorities).
 - (iii) 700m. Payments from other Government Departments.
 - (iv) 2·000m. Receipts from private practice.

126. The Central Pool for 1948-49 and 1949-50 was calculated on the basis of a betterment factor of 85 per cent and the Pool for 1950-51 and subsequent years has been based on a betterment factor of 100 per cent.

The Working Party on Distribution

127. The Working Party on the Distribution of Remuneration among General Practitioners reported in June, 1952,* and its recommendations were accepted by both the Government and the profession. Broadly, the changes introduced in the next financial year to implement its recommendations for the distribution of the Central Pool provided:—

- (a) for a reduction in the maximum number of patients which doctors are permitted to accept on their lists for General Medical Services.

The present limits are:—

3,500 for a single-handed practitioner (instead of 4,000)

4,500 for a member of a partnership, provided the average for the partnership is not above 3,500 (instead of 5,000 and 4,000 respectively)

2,000 in respect of the employment of a permanent assistant (instead of 2,400)

An additional "tolerance" of 100 may be allowed in respect of each principal and 50 in respect of an assistant.

- (b) for special allowances to be paid to doctors setting up a single-handed practice for the first time in areas most in need of more doctors. (See 116 (f));
- (c) for payment of a basic capitation fee of 17s. per patient, with a loading of 10s. for every patient between 501 and 1,500 on a doctor's list. Partnerships are allowed to share patients in the practice so as to secure the greatest benefit from the payments for loading.

The 2nd report of the Working Party in April, 1954, recommended payments to provide additional remuneration in the form of Supplementary Annual Payments to doctors adversely affected by the new arrangements (see paragraph 116 (h)).

The Level of Net Remuneration under the Danckwerts Award

128. The Spens recommendations on remuneration related to total net remuneration from all sources including private practice, not only to net

* Report of the Working Party of Representatives of the General Medical Services Committee of the British Medical Association and the Health Departments (H.M. Stationery Office, 1952).

remuneration for providing General Medical Services. As noted in paragraph 122, it was common ground in the abortive negotiations which preceded the adjudication that with the Spens addition of £173 per head the total pre-war net earnings of 17,900 doctors would have amounted to £19.89 millions per annum. This would have been an average of £1,111 net per doctor per annum. For 1950-51, the adjudicator applied a betterment factor of 100 per cent to the figure of £19.89 millions. Consequently the average net figure per doctor became £2,222 per annum. This figure included the value of the Exchequer contribution to the National Health Service Superannuation Scheme.

The Interim Increase of 1957

129. The arrangements for the remuneration of general practitioners providing general medical services continued to be designed to produce on average a net professional income of £2,222 per annum (including the value of the Exchequer superannuation contribution) until 1st May, 1957, when in pursuance of the Government's decision to give an interim increase of 5 per cent the figure of £2,222 became £2,333. It has been agreed to distribute the additional sum in the form of increased capitation fees and loadings, initial practice allowances, hardship and supplementary annual payments and grants for trainee general practitioners (see paragraphs 116 (a), (b), (f), (g), (h) and (m)).

Calculation of the Aggregate Amount of the Remuneration of General Medical Practitioners

130. Payments to general practitioners providing unrestricted general medical services are mostly derived from the Central Pool for Great Britain. Since the Danckwerts adjudication in 1951, the size of the Pool has been calculated annually at such an amount as will ensure that the earnings of practitioners from the Pool and from all other professional employments—e.g., from other services under Part IV of the National Health Service Act (e.g., Maternity Medical Services, sight-testing and provisions of drugs) and from work for hospitals, local authorities and Government Departments and from private patients—together with the Exchequer contributions to the National Health Service Superannuation Scheme will, on average, amount to £2,222 per annum (£2,333 since 1st May, 1957) after payment of the estimated total expenses entailed in running their practices (including payments made by practitioners to any locums they may employ).

131. It follows that under the present arrangements the size of the Central Pool depends upon:—

- (1) the number of doctors in Great Britain providing unrestricted medical services;
- (2) the level of those doctors' practice expenses;
- (3) their professional earnings for other work.

All these factors change and an annual recalculation is made of the amount to be provided by the Exchequer. It has been made in the following manner:

- A. The sum of £2,222 has been multiplied by the average of the number of doctors in unrestricted services on 1st July and 1st January of the financial year. By agreement with the profession certain doctors, who were not actually in the service on the relevant dates are included in the count. On the other hand, doctors who have had no patients on their lists for a year or who provide only restricted services or maternity medical services are excluded. The resultant figure has been the sum required to give to practitioners, on average, the total net remuneration due under the adjudicator's award.

- B.* An estimate of the aggregate practice expenses of those practitioners in the year in question has been made, sometimes with the assistance of information provided by the Board of Inland Revenue (in a completely anonymous form).
- C.* The sum of the amounts in *A* and *B* above is the aggregate gross amount that the practitioners as a body need to earn from all sources (including the value of the Exchequer superannuation contribution) so that the average net earnings (i.e., earnings after payment of practice expenses) are £2,222 per practitioner.
- D.* To determine the amount of the Central Pool the aggregate gross earnings as so calculated have been abated by the amount of the practitioners' earnings of the following kinds:—
- (i) payments for providing drugs, maternity medical services and sight-testing under the Supplementary Ophthalmic Services, etc.;
 - (ii) payments for work in the Hospital and Specialist Services;
 - (iii) payments for work done for Government Departments and local authorities;
 - (iv) earnings from private practice.

Information about the actual amounts earned under (i), (ii) and (iii) by the practitioners has been collected from the various services concerned. There is no information of actual earnings from private practice and each year so far the parties have conventionally and provisionally continued to use the figure of £2m. used by the adjudicator. Subtraction of the total of items (i)–(iv), together with the amount of the Exchequer contribution to superannuation, from the aggregate gross earnings (*C* above) has given the amount which had to be paid to the practitioners as a body in respect of their services in providing general medical services so that their net earnings from all sources would on average be £2,222 per practitioner.

In arriving at the total of the Pool an adjustment is made in respect of doctors with limited lists.*

132. The final calculation cannot be made until some time after the close of the financial year concerned for, as explained above, it is dependent on the collection of information about actual earnings of various kinds and expense levels in that particular year. Pending the final calculation each doctor is paid (in accordance with the report of the Working Party on the Distribution of Remuneration among General Practitioners) a capitation fee of 17s. (17s. 6d. from 1st May, 1957) per annum for every patient on his list and a loading of 10s. (11s. 6d. from 1st May, 1957) per annum for every patient within the range of 501 to 1,500 on his list. As mentioned in paragraph 115 certain other payments are made from the Central Pool. The total payments due to the doctors are normally made quarterly.

133. The Working Party envisaged that any further payment found to be due to the doctors when the Central Pool for the year had been finally calculated would be distributed as a percentage addition to the payments already made to each doctor by way of capitation fees and loadings for that year (see paragraph 27 of the Working Party's Report). So far there has always

* *Doctors with limited lists or liabilities*

- (i) Those with limited lists receive reduced capitation payments with no loadings.
 - (ii) Those with limited liabilities are paid reduced rates for both capitation and loadings.
- For the calculation of the Central Pool these doctors are counted as unrestricted.

been a balance left for distribution as a percentage addition to capitation fees and loadings.

134. For 1954-55, the latest year for which a final calculation has been made, the calculation was as follows:—

Number of doctors in Great Britain providing general medical services (other than doctors with limited lists)				21,133
<i>Calculation</i>				<i>£</i>
1. Total Net Income of 21,133 doctors at £2,222	...	...	...	46,957,526
2. Practice Expenses	...	...	...	23,549,227
3. Total Gross Income	...	...	...	70,506,753
4. Deduct:—				
				<i>£</i>
Part IV income (other than Pool and Inducement payments) of unrestricted doctors	...	5,106,351		
Other Income	...	4,805,695		
Exchequer Superannuation Contributions	...	3,183,128		13,095,174
5. Central Pool (unrestricted doctors)	...	...		57,411,579
6. Central Pool (restricted doctors)	...	...		81,749
7. Total Central Pool (including Exchequer Superannuation Contributions on the balance—item 8)	...	...		57,493,328
8. Less Exchequer Superannuation Contributions on balance	...	...		238,386
9. Central Pool for Great Britain for 1954/5	...	...		57,254,942
10. Amount already distributed (including £100,000 set aside for Group Practice Loans and £6,700 paid to the Shipping Federation)	...	...		52,998,050
11. Amount distributed as the balance of the Central Pool	...	...		4,256,892

The distribution of this balance took place in December, 1956.

135. The Central Pool for 1957-58 will, under existing arrangements, be calculated so as to produce an average net income of £2,222 from 1st April, 1957, increased to £2,333 from 1st May. The average for that year will therefore be about £2,325.

Maternity Medical Services

136. These Services are an integral part of General Medical Services. They consist of the provision of ante-natal care throughout pregnancy, attendance at the confinement if the doctor thinks it necessary or if he is called in by the midwife and subsequent post-natal supervision and care is given.

137. A woman may arrange to be given these services by :

- (a) a practitioner with approved obstetric experience* whose name is included in the obstetric part of the Medical List; there are 14,226 such practitioners in England and Wales;
- (b) her own doctor if she wishes whether or not his name is in the obstetric list.

138. A doctor on the obstetric list who has had responsibility for a patient throughout the pregnancy, confinement and post-natal period, is entitled to a fee of 7 guineas. Where services are provided during part only of the period a lower fee is payable.† When, in England and Wales, the services are provided by the woman's own doctor and he is not on the obstetric list the fees payable are five-sevenths of those payable to a doctor on the obstetric list.

Assistants and Trainee Assistants

139. The salary paid to an assistant is entirely a matter between him and his principal, not one which is covered in any way by regulation. Appendix S gives details of an analysis of the salaries offered to assistants in advertisements in the British Medical Journal. The results of this analysis were as follows:—

	1952/53	1954/55	1955/56	1956/57
Average salary including car allowance ...	£ 1,020	£ 1,046	£ 1,041	£ 1,055
Number of advertisements ...	210	210	160	195

Because of the effect of rare low and high salaries on the average calculated above, it may be useful to quote the median salary in each year which was as follows:—

	1952/53	1954/55	1955/56	1956/57
Median salary including car allowance ...	£ 1,000	£ 1,000	£ 1,000	£ 1,050

140. Under the special scheme under which selected general practitioners receive grants for the training of assistants, the salary paid to the trainee, including the value of board and lodging, is normally £775 (£850 from 1st May, 1957) per annum plus £150 car allowance (total £925 per annum; £1,000 per annum from 1st May).

Average age at which an assistant becomes a principal

141. Appendix T shows the number of assistants in each group who became principals in the years ending 1st July, 1955, and 1956, and the percentage that figure represents of the total. It will be seen that over 80 per cent of assistants who became principals do so before reaching the age of 36, and it would seem that the average age is in the early 30s.

SUPPLEMENTARY OPHTHALMIC SERVICES

142. Under these services persons are able to have their sight tested by ophthalmic medical practitioners or ophthalmic opticians and, if glasses are

(*) In Scotland there is no limitation of maternity medical services to practitioners with approved obstetric experience.

(†) Particulars may be found in paragraph 241 of the Handbook for General Medical Practitioners or paragraph F.65 of the Scottish handbook.

prescribed for them, to obtain these glasses from ophthalmic or dispensing opticians. Ophthalmic medical practitioners taking part in these Services must possess prescribed qualifications. Under Regulation 4 of the National Health Service (Supplementary Ophthalmic Services) Regulations, 1956, the practitioners with the prescribed qualifications are those who either:—

- (a) have held an appointment in the Hospital and Specialist Services with the status of consultant ophthalmologist or have held for two years an appointment of equivalent status as an ophthalmic surgeon or an assistant ophthalmic surgeon at an ophthalmic hospital or at a hospital with a special ophthalmic department approved by the Ophthalmic Qualification Committee; or
- (b) have obtained a recognised diploma or higher qualification in ophthalmology and have held for two years (six months of which must normally have been spent in a resident post) an appointment in an ophthalmic hospital or ophthalmic department of a hospital which has been approved by the Ophthalmic Qualification Committee;

and have satisfied the Minister, acting on the advice of the Ophthalmic Qualification Committee, that they have adequate experience.

143. The number of ophthalmic medical practitioners at 31st December, 1956 was about 980 (including 73 in Scotland). So far as is known, none work whole-time in the Supplementary Ophthalmic Services and as a rule this work is subsidiary to part-time employment in the Hospital Service or work in general practice. Of the total of about 5,400,000 sight tests made under the supplementary services in 1956 about 20 per cent (8 per cent in Scotland) were made by ophthalmic medical practitioners. Most of the sight tests made by these practitioners were made by practitioners who also held part-time appointments in the Hospital Service.

144. The practitioners are paid a fee per sight test made. This fee which represents gross remuneration for the service has been as follows:—

5th July, 1948	...	...	...	£1 11s. 6d. per sight test.
1st April, 1949	...	...	...	£1 5s. 0d. per sight test.
14th February, 1951	...	...	...	£1 0s 0d. per sight test.
1st July, 1957	...	...	...	£1 0s. 8d. per sight test.

The latter increase was given as an interim adjustment pending and without prejudice to the Royal Commission's recommendations.

The work of ophthalmic medical practitioners in the Supplementary Ophthalmic Services is not superannuable and this fact has been taken into account in settling the fees.

Questions of remuneration are discussed directly between the Health Departments and the Ophthalmic Group Committee of the British Medical Association. Under the plan for a Medical Whitley Council—see Appendix C—these questions would have been within the province of Committee A of the Council, but as already explained, this Committee has never functioned.

PART IV—GENERAL DENTAL SERVICES

Introductory

145. Section 40 of the National Health Service Act, 1946, and Section 39 of the National Health Service (Scotland) Act, 1947, place a duty upon Executive Councils to make arrangements with dental practitioners for the provision of dental treatment and appliances. By Regulation 2 (1) of the

National Health Service (General Dental Services) Regulations, 1954, and Regulation 2 (1) of the National Health Service (General Dental Services) (Scotland) Regulations, 1955, dental treatment provided under the general dental services is defined as all proper and necessary treatment which a dental practitioner usually undertakes for a patient, including examination and advice, the obtaining of radiographs, scaling, treatment of the gums, fillings, extractions, crowning, and the provision of artificial dentures and their repair. A detailed description of the arrangements for the provision of general dental services is given in the Handbook for General Dental Practitioners published by the Ministry of Health.

146. Any registered dentist may take part in the general dental services. To do so he applies to the Executive Council of the area in which he practices to have his name placed on the Council's dental list. A dentist is not restricted to accepting only patients who live in the area of the Executive Council on whose dental list his name appears; he may accept patients from any area. He may also carry on private practice.

147. In applying for admission to a dental list a dentist undertakes to abide by the Terms of Service for practitioners providing general dental services. These are set out in Part I of the First Schedule to the Regulations of 1954. Among the obligations which the dentist accepts under them are:—

- (a) to employ a proper degree of skill and attention -this does not mean a specialist or unusual degree of skill and care but the ordinary reasonable skill and care which a dentist would be expected to exercise in treating his patients;
- (b) to provide and complete satisfactorily all the treatment necessary to secure dental fitness which the patient is willing to have except in cases where the patient is accepted for emergency treatment only;
- (c) to provide proper and sufficient surgery and waiting room accommodation;
- (d) to be responsible for providing the services of a medical or dental practitioner when necessary for the administration of anaesthetic in connection with any operation undertaken by him;
- (e) to keep records in the manner prescribed in the Regulations;
- (f) in respect of any dental technician employed by him, to pay rates of wages and observe hours and conditions of work not less favourable than those approved for the time being by the National Joint Council for the Craft of Dental Technicians.

148. It has always been envisaged that general dental services, except where provided at health centres, would be provided by practitioners in independent practice. Section 11 of the National Health Service (Amendment) Act, 1949, provides that remuneration shall not consist wholly or mainly of a fixed salary except in special circumstances, or at a health centre.

149. Remuneration is by way of a fee per item of work except in the case of the dentists employed at health centres who are employed and paid on a salary basis. The current scale of fees which came into operation on 1st April, 1957, is embodied in the National Health Service (General Dental Services) Amendment Regulations, 1957, and the National Health Service (General Dental Services) (Scotland) Amendment Regulations, 1957. As an interim measure pending the Commission's report payments made under this scale have been increased by 2·6 per cent since 1st May, 1957 (see paragraph 170).

Number of practitioners

150. The number of practitioners (principals) on Executive Council lists on 1st January each year since 1949 has been:—

Year	England and Wales	Scotland	Total
1st January, 1949	8,570*	1,090	9,660
" 1950	8,800*	1,105	9,905
" 1951	9,000*	1,139	10,139
" 1952	8,850	1,154	10,004
" 1953	8,736	1,121	9,857
" 1954	8,519	1,089	9,608
" 1955	8,486	1,081	9,567
" 1956	8,531	1,073	9,604
" 1957	8,579	1,074	9,653

* These figures are estimates based on actual figures for the 1st July in the respective years.

Volume of work done

151. The total number of courses of treatment (including emergency treatment) completed each year from 1950 has been as follows:—

Year	Number of Treatments		
	England and Wales	Scotland	Total
1950	9,586,000	1,261,000	10,847,000
1951	9,965,000	1,253,000	11,218,000
1952	9,000,000	1,086,000	10,086,000
1953	8,375,000	1,049,000	9,424,000
1954	9,336,000	1,125,000	10,461,000
1955	9,924,000	1,201,000	11,125,000
1956	10,740,000	1,269,000	12,009,000

Payments made to Dentists for General Dental Services

152. The total sum earned by dental practitioners by way of fees for general dental services in each of the last five financial years for which information is available has been:—

Year	England and Wales	Scotland	Total
	£ million	£ million	£ million
1951/52	32·017	3·974	35·991
1952/53	26·592	2·909	29·501
1953/54	26·944	2·993	29·937
1954/55	29·377	3·254	32·631
1955/56	34·925	3·810	38·735

These sums include the charges paid by patients. They do not take account of the value of the Exchequer contribution to the National Health Service Superannuation Scheme.

Level of Remuneration

153. In 1946, a Spens Committee was appointed by the Minister of Health and the Secretary of State for Scotland to consider :—

“what ought to be the range of total professional income of a registered dental practitioner in any publicly organised service of general dental practice; to consider this with due regard to what have been the normal financial expectations of general dental practice in the past, and to the desirability of maintaining in the future the proper social and economic status of general dental practice and its power to attract a suitable type of recruit to the profession.”

154. The Committee had before them information about the gross and net incomes in the years 1936–1938 for practices in towns—they noted that the number of exclusively rural practices was negligible—and they found “that very few dentists make large incomes, that most dentists are making net incomes of less than enough to meet minimum middle-class expenditure, and that a quarter of the profession of necessity live below this standard” (paragraphs 9–12 of the report).

The Committee continued :—

“The evidence which we received emphasised two further and highly relevant facts. In the first place, the evidence both of the dental organisations and of individual practitioners leaves us in no doubt that the practice of dentistry is exceptionally arduous, involving as it does the performance by a dentist of intricate manual work at the chairside. Witnesses repeatedly emphasised that the great bulk of a dentist's working time “ . . . is spent in his surgery . . . and the greater part of it in actual operative work in the mouth, which is difficult of access . . . for the most part upon the conscious and apprehensive patient ”; and we were impressed by the unanimity of their evidence as to the resulting strain on the practitioner. We are convinced that this imposes a very real limit upon the number of hours that a dentist can be expected to work at the chairside without loss of efficiency. After exhaustive enquiry we reached the conclusion that 33 hours a week by the chairside for 46 weeks in a year, or say 1,500 chairside hours a year, together with the hours necessarily spent outside the surgery, represent full but not excessive employment and that, generally speaking, employment in excess of these hours tends to impair efficiency.

In the second place, recruitment to the dental profession over a long period has been far from satisfactory. The number of names on the Dentists Register today is only about one thousand more than it was twenty years ago; the number of students who qualified in 1946 was over one hundred less than the number in 1927; and, even so, a certain number of these students were studying dentistry only because they had been unable to secure vacancies as medical students. At the moment, the dental schools have as many students as they can accommodate, but this merely reflects the general abnormal position in which educational institutions throughout the country find themselves today. Unless the dental profession is made more attractive, there can be no guarantee that when the present abnormal situation has passed, the dental schools will remain full or that the hope of the Interdepartmental Committee on Dentistry that there will be a substantial increase in the student entry into these schools will be realised”. (Paragraphs 13 and 14 of the Report.)

155. In the Committee's judgment the rates of remuneration shown by the figures for 1936–1938 were inadequate when regarded in the light either of

the value of the services rendered by dental practitioners to the community, or of the importance of maintaining and improving recruitment to the profession (paragraph 15 of the Report).

156. The Committee proceeded to recommend an improvement in the 1938 rates of net remuneration "assuming a supply of dentists sufficient in relation to the demand for their services (even if not the need for these services) to secure a spread of incomes comparable to that in 1938". But as recommendations based on the 1938 distribution of incomes might have little or no relevance to the actual circumstances of the future they decided to make a recommendation as to the remuneration of an experienced single-handed dentist working efficiently and making full use of all appropriate assistance, fully employed but not working longer hours than 33 a week by the chairside for 46 weeks in a year, or say 1,500 chairside hours a year together with the hours necessarily spent outside the surgery. Their recommendation was that until there were sufficient dentists to secure a spread of incomes comparable to that of 1938 such a dentist should receive a net annual income of £1,600 a year (paragraphs 16-18 of the Report).

157. As with the other Spens Committees the recommendations on remuneration were expressed in terms of the 1939 value of money. The Committee commented in their report that they decided that in view of their constitution they were not qualified to form an opinion on the adjustment of pre-war incomes that would be required to produce corresponding incomes at the time they were reporting (May, 1948) and they endorsed the view of the Spens Committee on the Remuneration of General (Medical) Practitioners quoted in paragraph 119 above that the adjustment to conditions at the time of the Report should have direct regard to the change in the value of money and to the increases which had taken place since 1939 in incomes in other professions (paragraph 7 of the Report).

158. The other recommendations made on the remuneration of general dental practitioners were: -

- (1) If remuneration is determined by payments in respect of particular dental operations, these payments should be so balanced that over any considerable period remuneration should not be affected by the proportion of time spent upon dental operations of various types (paragraph 19 of the Report).
- (2) Additional remuneration could be earned: -
 - (a) by experienced practitioners under partnership agreements with junior partners or by the employment of salaried assistants (paragraph 21)
 - (b) by practitioners able to work more than 1,500 chairside hours a year without loss of efficiency as the Committee believed some dentists, especially among those below middle age would be able to do (paragraph 22)
 - (c) by practitioners with skill and experience in particular directions acting for part of their time in a consultant or specialist capacity at a higher rate of remuneration than they would obtain in general practice (paragraph 24).
- (3) Special provision should be made to secure adequate remuneration for dental practitioners serving sparsely populated areas, particularly those having to work from two or more surgeries a considerable distance apart (paragraph 26).
- (4) Additional payments should be made to induce dental practitioners to practise in especially unattractive areas (paragraph 26).

159. In a general comment the Committee made a comparison between their recommendations and those of the corresponding committee on the remuneration of general medical practitioners. The Committee first referred to the fact that the committee for general medical practitioners had found that the lower range of income in 1938 was too low and recommended an increase; and the Dental Committee expressed the view that the deficit in the case of dental practice was even bigger and recommended that bigger adjustments were required (paragraph 28 of the report). In connection with their recommendation for a net annual income of £1,600 for a single-handed practitioner the Committee commented:—

"In our judgment, based on a large volume of evidence, the work involved in earning this net annual income of £1,600 represents full, but not abnormally heavy work. After consideration, we took the corresponding figure for a general medical practitioner as £1,800. Our reasons were that since the earlier committee recommended that approximately 25 per cent of general medical practitioners should receive net incomes over £1,600 and thought it necessary to make special recommendations in order to secure a proportion of net incomes in excess of £2,000, that committee appeared to contemplate that single-handed practitioners would earn as much as £2,000 only exceptionally, and therefore presumably by unusually heavy work. In consequence, a figure halfway between £1,600 and £2,000 should represent with reasonable accuracy such a standard of full but not unusually heavy work as we had in mind. It appeared to us legitimate, therefore, to compare an income of £1,600 in the case of dental practitioners with an income of £1,800 in the case of general medical practitioners.

We believe it to be impossible to assess in terms of income the relative advantages and disadvantages of the two professions, their relative services to the community or their relative responsibilities. These factors must weigh rather in the minds of individuals in their choice of profession. There is, however, a particular factor, capable of assessment. By no means all the work a dentist has to do is at the chairside and 33 hours a week at the chairside means in general some 42 working hours a week. It appears probable, however, that a general medical practitioner would have to work, say from 50 to 55 hours a week to earn his £1,800 a year, or its present equivalent, and, since the bulk of his work would involve less intensive strain than a dentist's chairside work, we believe that he could do so with no greater difficulty. On the other hand, his actual leisure is very substantially less, and he can neither work fixed hours nor keep clear his week-ends to anything like the extent which in general is possible for a dental practitioner. These facts appear to us to justify the difference between the two figures for net incomes. In the above discussion, as throughout our report, incomes are expressed in terms of 1939 values."

Developments since the Spens Report

160. In the House of Commons on 27th May, 1948, the Minister of Health announced that the recommendations of the Spens Committee were accepted in principle and that discussions were about to take place with the profession on their detailed application. The Government raised the Spens figure of £1,600 a year net for a single-handed practitioner making full use of all appropriate assistance and working efficiently for 1,500 hours a year at the chairside, together with the hours necessarily spent outside the surgery, by 20 per cent. to £1,920 net, including the value of the Exchequer superannuation contribution, or £1,778 excluding the value of this contribution, by way of adjustment to current conditions. Practice

expenses were taken on the available evidence to be 52 per cent. of the gross earnings including the Exchequer Superannuation contribution. On this basis £3,858 gross had to be earned by way of fees to give £1,778 net. A scale of fees was worked out between the Health Departments and the profession which was intended to produce that level of gross remuneration on average for dentists working single-handed and fulfilling the conditions of work specified by the Spens Committee.

161. Negotiations on this matter took place directly between the Health Departments and the dental organisations. Though proposals were considered for the establishment of a Dental Whitley Council which would cover general dental practitioners as well as hospital dental staff and local authority dental officers, the dental organisations were unwilling to join in a Whitley Council for general practitioners and hospital dentists and the function of the Whitley Council that was established was restricted to local authority dentists.

162. The assumptions on timings and the distribution of work which underlay the 1948 scale of fees were largely falsified by the abnormal demand which the new service had to meet and in some cases the earnings were so high that measures had to be taken to control them. These measures may be summarised as follows:—

- (1) February, 1949. Where a dentist's average monthly earnings (gross) for work in the general dental services exceeded £400, he was paid 50 per cent. only of earnings in excess of £400.
- (2) 1st June, 1949. A new lower scale of fees was substituted for the 1948 scale and the ceiling "cut" described at (1) was ended. This scale represented an overall reduction of about 17 per cent.
- (3) 1st May, 1950. The fees in the 1949 scale were reduced by 10 per cent.

163. Meanwhile a Working Party had been set up to investigate timings of various dental operations and had reported in August, 1949. The Working Party found clear evidence that the majority of the dentists were working more than the Spens standard of 33 hours of chairside time per week (see paragraph 63 (3) of the Working Party's report*). The 10 per cent. reduction was intended as an emergency measure pending a review and possible revision of the scale of fees in the light of the Working Party's findings and after discussion with representatives of the profession. In May, 1951, however, charges for dentures were introduced and just over twelve months later—in June, 1952—charges for other dental treatment. The decline in demand (which proved to be temporary) following these measures led to a claim by the profession for the cancellation of the 10 per cent. reduction in the 1949 scale of fees. Though information was available of gross earnings for work in the general dental services, information was lacking on the actual amount of practice expenses and of earnings from other public sources and from private practice. In the absence of comprehensive information on dental remuneration the Ministers felt unable to entertain the claim, and after discussion it was agreed that the Health Departments and the British Dental Association should collaborate in an enquiry to obtain full facts about general dental practitioners' earnings and expenses in 1952 (in years of account ended between 31st December, 1952 and 4th April, 1953, to be exact). Discussions were also started with the Association on

* Report of the Working Party on Chairside Times taken in carrying out treatment by General Dental Practitioners in England, Wales and Scotland (H.M. Stationery Office, 1949).

the revision of the 1949 scale of fees in the light of the findings of the Working Party on Timings.

164. When the results of the enquiry into earnings and expenses became available, the British Dental Association renewed the claim that the 10 per cent. reduction in the 1949 scale should be cancelled; and in February, 1955, the Association lodged a further claim that practitioners engaged full-time in the National Health Service should have an average annual net income of £2,200.

165. In reply to the Association's claims, the Minister of Health and the Secretary of State for Scotland proposed in March, 1955, that the reassessment of dental remuneration and the recasting of the scale of fees, should be dealt with together, and that, as a full settlement of dental remuneration at that time, the revised scale should be worked out with the aim of producing a scale which, for the same volume of work, would give dentists the net incomes they would have received in 1952-53 had the 10 per cent. reduction not then been in force. For a larger volume of work the net income would be proportionately greater, and vice versa.

166. The Ministers offered, if the Association accepted these proposals as a full settlement of dental remuneration at that time, to cover the interim period while the revised scale was being worked out by cancelling the 10 per cent. reduction in the 1949 scale.

167. The Ministers' offer was accepted and the 10 per cent. reduction was accordingly cancelled from 1st May, 1955.

168. In introducing in the House of Commons on 12th July, 1955, the Supplementary Estimate to cover the additional cost entailed in 1955-56, the Minister of Health gave this indication of the effect of the agreement:—

"Under the new arrangement, average dentists will receive, including the Exchequer superannuation contribution, about £2,000 net. That compares with the general practitioner's average net income of rather more than £2,200. But it is calculated that single-handed dentists working without assistants, in the class with which the scale is particularly concerned, the 35-54 years old-age groups, will receive rather more than £2,400 net, so I think that the relativity between dentists and doctors in general practice has been kept well in mind as these arrangements were made."

169. The discussions with the profession on the revised scale of fees to replace the 1949 scale were concluded early in 1957, and, as already noted, the new scale came into operation on 1st April last. In connection with these discussions the Government Actuary advised that the expenses ratio for the period of the 1952-53 enquiry would have been 48·15 per cent. if the 10 per cent. reduction in fees had not then been operating.

Interim Increase of 1957

170. As already noted, on 1st May, 1957, payments made to dentists by way of fees in the new scale were increased by 2·6 per cent. (as the equivalent of an increase of 5 per cent. on net remuneration) as an interim measure pending the Royal Commission's report.

Average gross earnings for General Dental Services

171. Using total scale fees authorised for payment (including those for assistant dental practitioners—paragraph 174) in each financial year and the number of dentists (principals) on Executive Council lists on each 1st January

the average gross earnings per dentist (principal) has been (to the nearest £100):—

Year	England and Wales	Scotland	Great Britain
	£	£	£
1949/50	4,800	4,900	4,800
1950/51	4,300	4,400	4,300
1951/52	3,600	3,400	3,600
1952/53	3,000	2,600	3,000
1953/54	3,200	2,700	3,100
1954/55	3,500	3,000	3,400
1955/56	4,100	3,600	4,000
			(10 per cent. reduction in 1949 scale of fees cancelled from 1st May, 1955)
1956/57	4,500	3,900	4,400

These figures do not include the value of the Exchequer Superannuation contribution which amounts to 8 per cent of net earnings, which for this purpose are taken to be 48 per cent of gross earnings. (Thus in the case of gross earnings of £4,400 it is £169). The figures also do not include earnings from hospital work (paragraph 57) or from part-time service with local authorities or other bodies or from private practice.

Dentists at Health Centres

172. Where General Dental Services are provided from a Health Centre, the dentists engaged in the work are paid by the Executive Council on a salaried or sessional basis and not by way of a fee per item of work. The past and present rates of pay are shown below:—

Grade	5th July, 1948	15th August, 1953	1st May, 1957	Remarks
Grade I ...	£1,400 × £50 £2,000	£1,500 × £50 £2,000	£1,575 × £52 10s. -£2,100	—
Grade II ...	£900 × £35 - £1,495 × £5 - £1,500	£1,200 × £50 - £1,500	£1,260 × £52 10s. -£1,575	From 15th August, 1953, an employing authority had discretion to credit a practitioner with up to three annual increments on appointment in Grade III or on direct appointment in Grade II.
Grade III ...	£650 × £25 £900	£800 × £50 - £1,150	£840 × £52 10s. - £1,207 10s.	
<i>Sessional Rates:</i>				
Grade I ...	£4 4s. 0d.	£4 4s. 0d.	£4 8s. 0d.	Sessions of 3 hours—if regularly employed for 6 or more sessions per week, paid pro-rata to whole-time scale.
Grade II } Grade III }	£3 3s. 0d.	£3 3s. 0d.	£3 6s. 0d.	

173. There are 11 whole-time dentists employed at Health Centres. Of these 7 are in Grade I, 4 in Grade II and none in Grade III.*

* These figures include one Grade II dentist in Scotland.

Assistants

174. The dentist often starts in general practice as an assistant. On starting he may expect to earn up to about £1,500 a year which may be made up of a basic salary and a percentage of the value of the treatment he completes. Unlike assistants to general medical practitioners the assistant dentists are included in the Executive Councils' lists and are regarded as having similar responsibilities as principals.

175. Appendix U shows the ages of assistant dental practitioners who became principals in 1956. The average age for the change of status shown by the Table (except for the eleven whose age is not known) was *31 years*. If those who changed status after the age of 40 and who are possibly not following a normal career pattern are excluded, the average age for the change becomes *29 years*.

Method of entry into general dental practice as a principal

176. To become a principal in general dental practice the dentist may:—

- (1) take a partnership in an existing practice ;
- (2) purchase an existing single-handed practice ; or
- (3) establish a new practice for himself.

There are no restrictions on the areas in which he may practise.

177. In view of the general shortage of dentists, there is little difficulty today in establishing a new practice, provided the practitioner can raise sufficient capital to meet the cost of acquiring accommodation and equipment (which may amount to a considerable sum), and to meet expenses during the first few months until the regular flow of income begins. In these circumstances the goodwill of an existing practice tends to be of less value than in the past.

PART V—SUPERANNUATION

Introductory

178. This Part sets out the salient feature of the National Health Service Superannuation Scheme as it applies to doctors and dentists. It is divided into five sections:—

- Section A. General Provisions of the Scheme.
- Section B. Hospital Doctors and Dentists.
- Section C. General Medical Practitioners.
- Section D. General Dental Practitioners.
- Section E. Part-time Specialists.

A booklet which is issued without charge to every new entrant into the Scheme gives a fuller account.*

179. The legal basis of the Scheme is the National Health Service (Superannuation) Regulations, 1955, made under Section 67 of the National Health Service Act, 1946, and approved by an Affirmative Resolution of both Houses of Parliament. These regulations are applicable to England and Wales.

180. Everything said in this Part applies also to Scotland but the Scheme for Scotland is contained in the National Health Service (Superannuation) (Scotland) Regulations, 1955, made under Section 66 of the National Health Service (Scotland) Act, 1947.

* National Health Service Superannuation Scheme (England and Wales). An explanation (published by H.M. Stationery Office, 1956). There is a corresponding memorandum for Scotland.

A. GENERAL PROVISIONS OF THE SCHEME

181. The Scheme is compulsory and applies to all whole-time employees ; all general medical and dental practitioners and part-time specialists in the National Health Service ; some part-time employees and some assistants of general medical and dental practitioners.

Contributions and Service

182. The "employee" contribution is at the rate of 6 per cent of remuneration, the employing authority paying 8 per cent. Contributions are payable and service is reckonable up to age 70, except

- (i) in the case of general practitioners, who normally contribute to 65, but may carry on to 70 ;
- (ii) "mental health officers"—paragraph 191—who cease to contribute at 65.

The maximum number of years reckonable in any case is 45.

183. General practitioners' and part-time specialists' contributions are reduced on account of the National Insurance retirement pension by about £6 per annum. The contributions of other contributors are reduced by half this amount.

Benefits

184. These comprise:—

- (a) *Age retirement pension*—payable on retirement not earlier than age 60 after at least ten years' service.
- (b) *Incapacity pension*—payable on retirement through permanent incapacity after ten years' service.

Age and retirement pensions are, in general, reduced as from the age when the National Insurance retirement pension would become payable, by £1 14s. 0d. per annum for each year of service, subject to a maximum of £67 15s. 0d.

- (c) *Lump sum retiring allowance*—payable on retirement not earlier than age 60 after five years' service, or on retirement on permanent incapacity after ten years' service.
- (d) *Short service gratuity*—a lump sum payable on retirement on permanent incapacity after five years' service and before the completion of ten years, i.e. before any title to pension is acquired.
- (e) *Injury allowance*—an annual amount payable on retirement at any time through incapacity arising from:—
 - (i) injury sustained in the actual discharge of duty and specifically attributable to the nature of the duty ; or
 - (ii) disease contracted in the performance of duty.

The amount of the injury allowance is in all cases at the discretion of the Minister, subject to a maximum of 2/3rds of average remuneration.

- (f) *Death gratuity*—payable after five years' service where death occurs in service or after retirement on age, incapacity or injury.
- (g) *Widow's pension*—payable to the widow of a participant in the Scheme who dies after ten years' service, or of a pensioner. It is in

all cases equal to 1/3rd of the husband's pension, or of the pension he would have been entitled to had he retired on incapacity the day before his death.

Note: In no case is the total amount of benefits payable less than the amount of the "employee" contributions, with interest added at the rate of 2½ per cent per annum.

(h) *Allocation*—part of a pension may be allocated to provide a pension for a dependant or to add to a widow's pension on the death of the pensioner.

Service

185. Service reckonable in certain other superannuation schemes (e.g. under the Local Government Superannuation Act, 1937, a local Act scheme, Teachers' Scheme, Superannuation Acts (Civil Service)) can be aggregated with superannuable service in the Health Service Scheme provided there is not a break of twelve months between the employments.

Transfer to other employment and preservation of superannuation rights

186. There are interchange arrangements for the carrying of superannuable service to employment subject to the schemes referred to in paragraph 184, and to a number of other schemes, provided there is not a break of twelve months.

Preservation of rights while on National Service or on taking a short service commission

187.—(a) Participants in the Scheme going on national service may pay contributions if they wish that service to count. In any case they must go back to superannuable employment in the Health Service Scheme, or one of the schemes referred to above, within six months of the end of their national service to preserve their superannuation rights.

(b) Doctors and dentists

(i) taking short service commissions in H.M. Forces for not exceeding eight years; or

(ii) becoming engaged by the War Office as civilian medical specialists for not exceeding two years may pay employee and employer contributions (generally deducted in bulk at the end of their commission, from their service gratuity) and must return to superannuable employment within twelve months of the end of such service. If they do not return they lose their accrued superannuation rights.

B. HOSPITAL DOCTORS AND DENTISTS

188. The Scheme is applied to doctors and dentists employed full-time in the hospital service, to part-time registrars and to other part-time doctors and dentists who are also in general practice in the same way as for all other salaried employees except that in the case of those also in general practice the part-time hospital post is treated for benefit purposes as though it were general practitioner service (see paragraphs 198 and 204).

Remuneration

189. Remuneration for hospital doctors and dentists comprises salary and fees paid to the officer for his own use; these include distinction awards, fees for domiciliary work (excluding apparatus fees), bed fund payments and the money value of allowances in kind.

Benefits

190.—(a) *Age retirement pension*

This is calculated on the basis of $1/80$ th of average remuneration over the last three years of Service for each year of contributing service up to a maximum of 45.

(b) *Incapacity pension*

The basis of calculation is the same as that for the age retirement pension but subject to a minimum based on twenty years' service, or the number of years service which could have been completed before attaining the age of 65, whichever is the less.

(c) *Lump sum retiring allowance*

This is equal to $3/80$ ths of average remuneration for each year of contributing service up to 45 years, except that in the case of a married man whose wife may become entitled to a widow's pension the basis is $1/80$ th.

(d) *Short Service Gratuity*

This is equal to average remuneration over the last three years of service.

(e) *Death Gratuity*

This is equal to the greatest of

- (i) $3/80$ ths of average remuneration for each year of contributing service ; or
- (ii) the officer's contributions, with interest ; or
- (iii) the amount of average remuneration over the last three years of service ;

Except that where a widow's pension is payable under the Scheme the death gratuity is $1/80$ th of average remuneration for each year of contributing service. In all cases payments already made by way of pension, etc., are deducted from the death gratuity.

Mental Health Officers

191. A doctor who devotes substantially the whole of his time to the treatment of mental patients or defectives in a hospital or institution is classified as a mental health officer and may retire at age 55 if he has then completed twenty years' service as such. After twenty years' contributing service as a mental health officer each further year of contributing service as a mental health officer over twenty counts as two for calculating pension, retiring allowance or death gratuity. Contributions cease to be payable and service ceases to be reckonable at age 65.

C. GENERAL MEDICAL PRACTITIONERS

Remuneration

Principal Practitioners

192. The superannuable remuneration of a principal practitioner on which contributions are payable comprises all payments made by the Executive Council to him in respect of general medical services and pharmaceutical services provided by him plus the statutory charges payable to the practitioner by the patient for drugs and appliances less a sum on account of practice expenses, and less the approved remuneration of any assistant employed by him.

193. Practice expenses of a general medical practitioner are calculated as follows:—

- (i) The whole of any allowance made to him for an additional car for an assistant who is being trained in general practice.
- (ii) 50 per cent of all payments to him in respect of pharmaceutical services and of all mileage payments.
- (iii) 30 per cent of all other payments to him for general medical services except those for supervising the training of an assistant.

194. *Where two or more medical practitioners are in partnership* the total superannuable remuneration of the partnership calculated as above is allocated to the individual members in equal shares, unless they ask to have it allocated on the basis of their shares in the partnership profits, which is a common arrangement. This provision has been made at the request of the British Medical Association.

Assistant Practitioners

195. An assistant to a medical practitioner is not superannuable unless he is wholly or mainly employed, i.e. over 50 per cent of his time, in assisting his employer in the actual discharge of his duties as a practitioner on the list of an Executive Council. Further, the assistant is only superannuable when the principal is required to obtain the Executive Council's consent to the employment, i.e. where the assistant is employed for three months or longer.

196. The superannuable remuneration is the amount approved by the Executive Council on behalf of the Minister as representing the proportion of the salary and emoluments paid to the assistant by the principal practitioner which is attributable to the treatment and care of National Health Service patients.

197. The age up to which a practitioner, both principal and assistant, is required to contribute is normally 65, but before reaching that age the doctor can apply for an extension up to age 70. The practitioner may, of course, subject to being retained on an Executive Council's list, continue in practice after reaching this age.

Benefits

198. Age Pensions

- (a) instead of this being based on 80ths of average remuneration during the last three years of service it is, in the case of a principal and an assistant medical practitioner, calculated on the basis of $1\frac{1}{2}$ per cent of the total superannuable remuneration received by him during the last 45 years reckonable service under the Scheme, or the whole period of the service if that is less than 45 years.

(b) Incapacity Pension

The pension is $1\frac{1}{2}$ per cent of the practitioner's total superannuable remuneration but as in the case of hospital doctors, there is a minimum based on the remuneration which could have been earned in twenty years or the number of years of service which could have been completed before attaining the age of 65, whichever is the less.

(c) Retiring Allowance

This is $4\frac{1}{2}$ per cent of the total superannuable remuneration, except that in the case of a married man whose wife may become entitled to a widow's pension it is $1\frac{1}{2}$ per cent of the amount.

(d) *Death Gratuity*

This is equal to the greatest of:—

- (i) $4\frac{1}{2}$ per cent of total remuneration, or
- (ii) the doctor's contributions with interest, or
- (iii) the amount of the average remuneration over the last three years of service.

Except that where a widow's pension is payable the death gratuity is $1\frac{1}{2}$ per cent of total remuneration. In all cases payments already made by way of pensions, etc., are deducted.

199. The basis of calculating the benefits of practitioners was agreed following representations made by the British Medical Association Negotiating Committee who contended that as the practitioner's remuneration reaches its maximum between the ages of 35 and 50 the fractional basis on average remuneration over the last three years of service adopted for hospital doctors would be unfair. It was calculated actuarially that $1\frac{1}{2}$ per cent of total remuneration would be the equivalent of the fractional basis.

D. GENERAL DENTAL PRACTITIONERS

Remuneration

Principal Dental Practitioners

200. Remuneration means all payments made by the Executive Council to the practitioner in respect of general dental services provided by him plus the statutory charges for those services which are payable by the patient to the dentist, less a sum on account of practice expenses equivalent to 52 per cent of all the aforesaid payments and less the approved remuneration of any assistant practitioner employed by him.

201. The principal's superannuable remuneration is subject to a maximum of £3,500 per annum.

202. *Dental practitioners in partnership* may ask to have the total superannuable remuneration of the partnership, calculated as above, allocated between them on the basis of their shares in the partnership profits. If they do not apply for this to be done, each partner's remuneration is calculated on his individual remuneration as defined above.

Assistant Dental Practitioners

203. Their remuneration for superannuation purposes is approved in the same way as that of assistant medical practitioners.

Note: The stipulation applicable to assistant medical practitioners that the assistant is only superannuable if the principal is required to obtain the consent of the Executive Council to the employment does not apply to an assistant to a dental practitioner.

Benefits

204. The basis of calculation is the same as for medical practitioners except that for the purpose of calculating the amount of a short service gratuity or death gratuity the average remuneration of a dental practitioner is calculated over the whole period of his service as such instead of over the last three years. This special method of calculation for the dental practitioner was agreed at the request of the British Dental Association as being fairer to the dental practitioners (whose remuneration, like that of the medical practitioner, tends to decrease towards the end of his career).

E. PART-TIME SPECIALISTS

205. This section applies to persons rendering part-time specialist services pursuant to Section 3 of the National Health Service Act, 1946, to a Regional Hospital Board or Board of Governors of a teaching hospital.

Remuneration

206. This comprises sessional fees for such services and fees for domiciliary and exceptional consultations. A distinction award is also superannuable.

Benefits

207. These are calculated on the same basis as those for general medical practitioners but see next paragraph.

208. A part-time specialist spending not less than nine notional half-days a week in that capacity may, however, apply to the Minister to direct that the alternative method, i.e., 80ths of average remuneration over the last three years of service, be used to calculate benefits earned in such service.

PART VI—OTHER CONNECTED OCCUPATIONS

209. The first paragraph of the Royal Commission's terms of reference mentions "connected occupations". In a statement published on 12th April, 1957, the Royal Commission indicated that they took this phrase to refer, *inter alia*, to hospital administrators, nurses and medical auxiliaries.

210. For certain classes in the above-mentioned groups of staff Appendix V contains tables showing the past and current salary scales together with the principal items in their conditions of service; the classes concerned are:—

Administrative and clerical staff employed by hospital authorities, hospitals and Executive Councils	Appendix V	Section 1
Architects and Engineers employed by Regional Hospital Boards	"	" 2
Hospital nursing staff	"	" 3
Medical Laboratory Technicians	"	" 4
Dental Technicians	"	" 5
Physiotherapists, Almoners, Radiographers	"	" 6
Hospital Pharmacists	"	" 7
Hospital Opticians	"	" 8
Hospital Biochemists and Physicists	"	" 9

The total number of classes in the group of staff in paragraph 209 is very large (e.g., there are no fewer than about 160 salary scales for hospital nurses) and information has not been given for everyone of them, firstly, because of the sheer volume of that information and, secondly, because it is probable that information about some of the classes (e.g., Dark Room Technicians) would be of little relevance to the task of the Royal Commission. The classes which have been selected for inclusion in the Appendix are representative of a wide range of employment and salaries, but if the Royal Commission require information about specific classes not included this can be provided.

211. There is one important element of pay which is not given in Appendix V because it is common to all the classes covered and is, therefore, more conveniently set out here. This is "London Weighting" which is paid to non-resident staff whose place of employment is within the Metropolitan Police Area. The amounts payable are as follows:—

Under age 21	...	...	...	£10 p.a.
Age 21 to 25	...	...	...	£20 p.a.
Over age 25	...	...	...	$\left\{ \begin{array}{l} \text{£30 p.a. on salaries up to £800} \\ \text{£40 p.a. on salaries £801-£1,000} \\ \text{£50 p.a. on salaries over £1,000} \end{array} \right.$

London weighting is not paid to doctors or dentists.

212. The groups of staff in paragraph 209 enjoy the benefits of a sick-pay scheme similar to that applicable to hospital medical and dental staff set out in Appendix I.

APPENDIX A

SHEET 1—MEDICAL

Estimated Numbers of Medical Staff, by grades, from 1951 to 1955 (Great Britain)

Grade	1951	1952	1953	1954	1955	Increase or Decrease 1951-1955	
						Numbers	Percentage
Consultants	6,356	6,752	6,945	7,073	7,244	888	14.0
Senior Hospital Medical Officers	2,420	2,492	2,528	2,586	2,637	217	9.0
Senior Registrars	1,547	1,296	1,195	1,253	1,262	-285	-18.4
Registrars	1,856	2,111	2,259	2,446	2,620	764	41.2
Junior Hospital Medical Officers	623	599	636	652	764	141	22.6
Senior House Officers	1,458	1,657	1,830	1,940	2,032	574	39.4
House Officers	3,384	3,339	3,100	3,190	3,203	-181	-5.4
TOTAL	17,644	18,246	18,493	19,140	19,762	2,118	12.0

NOTES:

- The figures, other than those for the consultant grade (for which nominal rolls have been maintained from 1949), are estimates in so far as there are part-time appointments as well as whole-time appointments in the various grades. The factor may be a significant one in relation to the figures for senior hospital medical officers in 1951-1952 (which in the case of this particular grade must be treated with reserve) but not later. In the lower grades there are relatively few part-time staff.
- The figures for consultants which include some employed by the Board of Control and the Public Health Laboratory Service, are those used by the Advisory Committee on Merit Awards and exclude consultants ineligible for awards. Those excluded are mainly consultants aged 70 or more holding honorary appointments and are relatively few and the amount of time for which they work in the Hospital Service is likely to be much below the average.
- There is a small amount of duplication between the figures for Consultants and those for (a) Senior Hospital Medical Officers and (b) Senior Registrars owing to the fact that some persons hold posts both as part-time Consultants and part-time Senior Hospital Medical Officers or Senior Registrars. These cases, however, are not numerous; e.g., in England and Wales at June, 1956, they numbered:—
 - Part-time consultants also holding part-time S.H.M.O. posts ... 81
 - Part-time consultants also holding part-time Senior Registrar posts ... 42
- The figures for House Officers include also dental House Officers.

Estimated Numbers of Dental Staff by grades, from 1951-1955 (Great Britain)

Grade	1951	1952	1953	1954	1955	Increase or Decrease 1951-1955	
						Num- bers	Per- centage
Consultants	261	273	282	279	282	21	8.1
Senior Hospital Dental Officers	228	257	257	260	263	35	15.4
Senior Registrars	36	34	34	39	45	9	25.0
Registrars	43	50	51	53	59	16	37.2
Senior House Officers...	11	14	19	16	20	9	81.8
House Officers (Note 3) ...	—	—	—	—	—	—	—
TOTAL	579	628	643	647	669	90	15.5

NOTES:

1. The figures, other than those for the consultant grade (for which nominal rolls have been maintained from 1949) are estimates in so far as there are part-time appointments as well as whole-time appointments in the various grades. The factor may be a significant one in relation to the figures for S.H.D.O. in 1951-1952 (which in the case of this particular grade must be treated with reserve) but not later. In the lower grades there are relatively few part-time staff.
2. The figures for consultants are those used by the Advisory Committee on Merit Awards and exclude consultants ineligible for awards. Those excluded are mainly over 70 and are few in number.
3. The figures for dentists are included in the figures for doctors in Sheet 1.

APPENDIX B

HOSPITAL MEDICAL AND DENTAL STAFF

Whole-time Salaries recommended by the Spent Committee on the Remuneration of Consultants and Specialists and whole-time salaries paid since the inception of the National Health Service on 5th July, 1948

Grade (1)	Salary recommended by Spent Committee (2)	Salary as from 5th July, 1948 (3)	Salary from 1st April, 1954 under agreement on Medical Whitley Council (4)	Current salary and date from which operative		Remarks (7)
				Salary (5)	Operative Date (6)	
Consultant	£1,250 at age 30 or less £1,375 at age 31 £1,500 at age 32 × £125-£2,500	£1,400 at age 30 or less £1,550 at age 31 £1,700 at age 32 × £125-£2,075 × £130-£2,375 × £125-£2,750	£1,800 at age 30 or less £1,950 at age 31 £2,100 at age 32 × £125-£3,100	£1,890 at age 30 or less £2,047.10.0 at age 31 £2,205 at age 32 × £131.5.0-£3,255	1st May, 1957	Distinction awards in addition to basic salary are paid as follows:— A. Awards at the whole-time rate of £2,500 p.a. to 4 per cent. of the total number of consultants. B. Awards at the whole-time rate of £1,500 p.a. to 10 per cent. C. Awards at the whole-time rate of £500 p.a. to 20 per cent. Since 1st April, 1954, the basic salary scale of holders of awards of £2,500 and £1,500 has been abated by £300 and £200 respectively so that e.g. the maximum amount the holder of an award of £2,500 may be paid by way of salary and award together is £5,455. The increased salaries for the consultant and senior hospital medical officer grades from May, 1957, implement the Government's decision to give these grades an increase of 5 per cent. as an interim measure. The increase of £75 on the 1954 figures operated from 26th April, 1956, under agreement reached on the Medical Whitley Council after an arbitration award by the Industrial Court.
Senior hospital medical officer Senior hospital dental officer	No recommendation	£1,300 at age 32 × £50-£1,750 (£1,200 at age 30 or less £1,250 at age 31 from November, 1952)	£1,400 at age 30 or less £1,450 at age 31 £1,500 at age 32 × £50-£1,950	£1,548.15.0 at age 30 or less £1,601.5.0 at age 31 £1,653.15.0 at age 32 × £52.10.0-£2,126.5.0	1st May, 1957	

The increased salaries for the senior registrar and the following grades from 1st April, 1957, implement the Government's decision to give these grades an increase of 10 per cent. as an interim measure.

	1st April, 1957	1st April, 1957	1st April, 1957
Senior Registrar ...	£900 × £100 - £1,200	£1,000 × £100 - £1,300	£1,210 × £110 - £1,540
Registrar ...	£700 1st year £800 2nd and any subse- quent year	£775 1st year £890 2nd and any subse- quent year	£935 1st year £1,061.10.0 2nd and any subse- quent year
Junior hospital medical officer	No recommen- dation	£700 × £50 - £1,000	£852.10.0 × £55 -£1,182.10.0
Senior house officer	£600	£670	£819.10.0
House officer ...	No recommen- dation	At the rate of— £350 p.a. for first post held £400 p.a. for second post held £450 p.a. for the third and any subse- quent posts held	At the rate of— £467.10.0 £522.10.0 or £577.10.0 p.a. for each post of six months duration

Under a Whitley agreement of January, 1955, the house officer rates became payable as follows in the case of medical staff only:—

(i) Provisionally registered practitioners.

Lowest rate of salary became payable for the first post held.

Second rate of salary became payable for the second and all subsequent posts held.

(ii) Fully registered practitioners.

Highest rate of salary became payable for any post held.

APPENDIX C

WHITLEY COUNCILS FOR THE HEALTH SERVICES (GREAT BRITAIN) MEDICAL WHITLEY COUNCIL.

CONSTITUTION

1. Title

The Council shall be known as the "Medical Whitley Council of the Whitley Councils for the Health Services (Great Britain)". The short title of the Council shall be the "Medical Whitley Council".

2. Area

The sphere of operation of the Council shall be England, Wales and Scotland.

3. Functions of the Council

The functions of the Council shall be:—

- (i) To secure the greatest possible measure of co-operation between the Authorities responsible for the Nation's health and medical practitioners engaged in the health services, with a view to increased efficiency in those services and the well being of those engaged in them.
- (ii) To provide machinery for the consideration of the remuneration and conditions of service of medical practitioners within the ambit of Section 66 of the National Health Service Act, 1946, or Section 65 of the National Health Service (Scotland) Act, 1947.
- (iii) To provide machinery for the consideration of the remuneration of medical practitioners with whom an Executive Council may make arrangements for the provision of general medical services, including maternity medical services, under Section 33 of the National Health Service Act, 1946, or Section 34 of the National Health Service (Scotland) Act, 1947, or for the provision of supplementary ophthalmic services under Section 41 of the National Health Service Act, 1946, or Section 42 of the National Health Service (Scotland) Act, 1947.
- (iv) To provide machinery for the consideration of the remuneration of medical practitioners with whom Regional Hospital Boards, Boards of Governors of Teaching Hospitals, Hospital Management Committees, Boards of Management, or local health authorities may make arrangements for the provision of particular services under the National Health Service Act, 1946, or the National Health Service (Scotland) Act, 1947.
- (v) To provide machinery also for the consideration of the remuneration and conditions of service of medical practitioners employed by, and the remuneration of medical practitioners in contract with, local authorities outside the National Health Service.

4. Machinery

- (i) There shall be a Council composed as prescribed in Clause 5 below.
- (ii) The Council may appoint such Committees as may be considered necessary and shall appoint three Committees, namely:—

Committee A, which shall deal with the remuneration of medical practitioners providing general medical services, including maternity medical services, under Section 33 of the National Health Service Act, 1946, or Section 34 of the National Health Service (Scotland) Act, 1947, or providing supplementary ophthalmic services under Section 41 of the National Health Service Act, 1946, or Section 42 of the National Health Service (Scotland) Act, 1947.

Committee B, which shall deal with the remuneration and conditions of service of medical practitioners employed by, or in contract with Regional Hospital Boards, Boards of Governors of Teaching Hospitals, Hospital Management Committees or Boards of Management.

Committee C, which shall deal with the remuneration and conditions of service of medical practitioners employed by, and the remuneration of medical practitioners in contract with local authorities.

- (iii) Any Committee of the Council may appoint such sub-committees as may be considered necessary. The Management and Staff Sides of such sub-committees may include representatives of organisations not represented on the Committee.

5. Membership

- (i) The Council shall consist of 40 members, of whom 19 shall be appointed to represent the Management, and 21 to represent the Staff.

- (ii) The 19 representatives of the Management shall be appointed as follows:—

Ministry of Health	4
Department of Health for Scotland	1
Regional Hospital Boards—	
England and Wales	4
Scotland	2
Boards of Governors of Teaching Hospitals in	
England and Wales	2
County Councils Association	1
Association of Municipal Corporations	1
London County Council	1
Scottish Local Authority Associations	1
Association of Hospital Management Committees	2

- (iii) The 21 representatives of the Staff shall be appointed as follows:—

The Joint Committee of the Royal Colleges, the Royal	
Scottish Corporations, and the Central Consultants	
and Specialist Committee	7
The General Medical Services Committee	7
The Public Health Committee of the British Medical	
Association	7

6. Representation on Main Committees

The representatives of the Management and Staff Sides on the three Committees A, B and C shall be appointed as follows:—

Committee A General Medical Services

Management representatives:

Ministry of Health	6
Department of Health for Scotland	2
Local Authority Associations	1 (observer)

Staff Representatives:

The General Medical Services Committee	9
Total	18

Committee B Hospital and Specialist Services

Management representatives:

Ministry of Health	4
Department of Health for Scotland	1
Regional Hospital Boards—	
England and Wales	4
Scotland	2
Boards of Governors of Teaching Hospitals in England	
and Wales	2
Association of Hospital Management Committees	2
Local Authority Associations	2 (observers)

Staff representatives:

The Joint Committee of the Royal Colleges, the Royal	
Scottish Corporations, and the Central Consultants	
and Specialists Committee	19
Total	36

Committee C—Public Health Services

Management representatives:

County Councils Association	...	...	...	5
Association of Municipal Corporations	...	...	...	5
Urban District Councils Association	...	...	...	1
Rural District Councils Association	...	...	...	1
London County Council	...	...	...	2
Association of County Councils in Scotland	...	...	...	1
Counties of Cities Association (Scotland)	...	...	...	1
Convention of Royal Burghs (Scotland)	...	...	...	1
Ministry of Health	...	...	...	1 (observer)
Department of Health for Scotland	...	...	...	1 (observer)

Staff representatives:

The Public Health Committee of the British Medical Association	...	...	...	...	...	13
Total						32

7. Retirement of Members

- (i) Representatives shall retire from the Council or from Committees A, B or C on ceasing to be members of or to hold office under the authority, body, organisation or department by which they were appointed.
- (ii) The members of the Council and of Committees A, B and C shall retire on the thirty-first day of July of each year and shall be eligible for re-appointment. Casual vacancies shall be filled by the original appointing body, which shall appoint a member to sit until the end of the current period.

8. Additional Members

- (i) The Council may appoint on any of its Committees other than Committees A, B or C, additional members being representatives of organisations having a special interest in a particular matter, or persons not being members of the Council, as may serve the purposes of the Council.
- (ii) The Council may co-opt for any of its meetings representatives of organisations having a special interest in a particular matter, or persons not being members of the Council as may serve the purposes of the Council. Any Committee of the Council may co-opt for any of its meetings representatives of organisations having a special interest in a particular matter, or persons not being members of the Committee, as may serve the purposes of the Committee. Co-opted members shall serve only in a consultative capacity.

9. Chairman

The Council and Committees A, B and C shall each appoint annually, at the first meeting held after 31st July, a chairman and vice-chairman. The chairman shall be appointed alternately from the Management and Staff Sides. If the chairman is a representative of the Management, the vice-chairman shall be a representative of the Staff, and vice versa.

10. Secretaries and other Officers

The Council and Committees A, B and C shall appoint Joint Secretaries and such other Officers as the Council or Committee may think fit. The persons so appointed may or may not be members of the Council or Committee.

11. *Quorum*

- (i) A quorum of the Council and of Committees A, B and C shall consist of not less than one third of the members entitled to be present on each side. In the absence of a quorum the chairman shall vacate the chair, and the business remaining to be considered shall be the first business to be discussed at the next meeting, being either an ordinary meeting or a special meeting convened under Clause 13.
- (ii) The quorum of any other Committee of the Council shall, subject to any directions given by the Council, be determined by the Committee.
- (iii) The proceedings of the Council or a Committee of the Council shall not be invalidated by any vacancy in their number or by any defect in the appointment of any member.

12. *Deputies*

Where a member of the Council or a Committee of the Council is unable to attend any meeting, the body responsible for his appointment may send a deputy. A deputy shall have the right to speak and to vote as if he were a substantive member.

13. *Meetings*

Meetings of the Council and of Committees A, B and C shall be held as often as required. The chairman of the Council or of Committees A, B or C may, and upon a requisition from one third of either side shall, call a special meeting of the Council or Committee. The requisition and also the notice summoning the meeting shall state the nature of the business proposed to be transacted, and a requisitioned meeting shall take place within 21 days after the receipt of the requisition by the chairman. No business shall be transacted at any special meeting other than that specified in the notice summoning the meeting.

If a special meeting is called and the business cannot be transacted owing to the absence of a quorum, the chairman may convene another special meeting.

14. *Decisions*

- (i) Decisions of the Council and of Committees of the Council shall be reached by the concurrence of both sides. The decisions of Committees A, B and C shall not require the approval of the Council. The decisions of any other Committee shall require the approval of the Council unless power to decide has been formally delegated to that Committee by the Council.
- (ii) The decisions of the Council and of Committees A, B and C shall be transmitted to the Minister of Health, the Secretary of State for Scotland, and the local authorities concerned.

15. *Arbitration*

Every effort shall be made to accommodate differences of opinion between the two sides of the Council or of Committees A, B and C, as the case may be, in order to reach an agreed decision. Where it is impossible to accomplish this, it shall be open to the Management or the Staff organisations concerned to seek arbitration in accordance with the terms of an arbitration agreement to be determined by the General Council.

16. *Finance*

The cost of any activity undertaken by the Council or by a Committee of the Council shall be divided equally between the Management and Staff Sides, unless otherwise determined by the Council or, in the case of Committees A, B and C, by the Committee.

17. *Minutes*

Minutes agreed by the Joint Secretaries shall be made for each Council or Committee meeting. The minutes of meetings of the Council and the decisions of Committees A, B and C shall be circulated to each member of the Council,

to the Secretaries of each other functional Council, and to every member of the General Council. The minutes of each committee meeting shall be circulated to each member of the Committee and to each member of the Council.

18. *Amendment of Constitution*

The Constitution of the Council may be varied at any meeting of the Council provided that notice of the terms of the proposed amendment has been circulated to each member of the Council at least 28 days before the meeting, and subject to the consent of the General Council in regard to any amendment modifying the provisions of the Main Constitution of the Whitley Councils for the Health Services (Great Britain).

19. *Interpretation*

Nothing in this constitution shall be interpreted as over-riding any provisions which may be adopted in the Main Constitution of the Whitley Councils for the Health services (Great Britain).

(This constitution was adopted at a meeting of the Medical Whitley Council held on 26th January, 1950.)

APPENDIX D

EXTRACT FROM THE SUPPLEMENT TO THE BRITISH MEDICAL JOURNAL OF
SATURDAY, 10TH APRIL, 1954

REMUNERATION OF HOSPITAL MEDICAL STAFF

Statement by SIR RUSSELL BRAIN, Chairman of Staff Side of Committee "B"
of the Medical Whitley Council

NEW INCREASES AGREED

Committee "B" of the Medical Whitley Council has reached agreement on increases in the rates of pay of hospital medical staff which have been in operation since 1948.

The agreement, which has effect from 1st April, includes the following provisions:—

- (i) The basic scale for consultants is to be £2,100, rising by annual increments of £125 to £3,100. This new scale gives an increase over the 1948 scale of £400 at the minimum and of £350 at the maximum.
- (ii) The new basic scale applies to consultants with C distinction awards, who therefore obtain the same increase as consultants without distinction awards.
- (iii) The increases for consultants with B and A distinction awards are, however, limited to £150 and £50 respectively.
- (iv) The basic scale for senior hospital medical officers is to be £1,500, rising by annual increments of £50 to £1,950, an increase of £200 over the 1948 scale.
- (v) Senior registrars will receive £1,100, £1,200, £1,300, or £1,400, according to their year of service, an increase of £100 over the 1948 rates.
- (vi) Registrars will receive £850 or £965, according to their year of service, an increase of £75 over the 1948 rates.
- (vii) Junior hospital medical officers will receive a scale of £775, rising by annual increment of £50 to £1,075, an increase of £75 over their 1948 scale.
- (viii) Senior house officers will receive £745, an increase of £75 over their 1948 salary.
- (ix) House officers are to receive an annual rate of £425 for the first, £475 for the second, and £525 for the third and subsequent posts, an increase of £75 over the 1948 rates, but the annual charge made to them for residence is to be increased by £25.

(x) A maximum of three-quarters of a session is to be placed on the weighting that part-time consultants and senior hospital medical officers are allowed when their salaries are calculated. This replaces the present maximum weighting of one and one-quarter sessions.

(xi) There is a protection against any individual losing pay on the coming into operation of the new agreement.

The details of the new arrangements are being worked out by the two sides of Committee "B", and the full agreement will be transmitted to the Minister of Health and the Secretary of State for Scotland as soon as it is ready.

These increases are the final outcome of lengthy negotiations, and should be judged in the light of the following background and history of events.

History

Before the introduction of the National Health Service it was agreed that the range of remuneration for both general practitioners and consultants in that Service should be determined by two interdepartmental committees, both under the chairmanship of Sir Will Spens. The Minister of Health and Secretary of State for Scotland on the one hand, and the profession on the other, agreed to accept the recommendations of these committees, which became in effect the basis on which professional income in the National Health Service was fixed.

The recommendations of the Spens Committees were framed in terms of the 1939 value of money, and both committees explicitly stated that they "left it to others to make the necessary adjustment to present-day values, such adjustment to have regard not only to changes in the value of money, but to increases in income which had in fact taken place in other professions since 1939". The Consultant Spens Committee went further and stated that the adjustment should have regard to changes in income in other branches of the medical profession.

The Consultant Spens Report was not published until May, 1948, and when the National Health Service was introduced in July of that year hospital staff entered the new Service on interim terms, relying on the assurance that the Minister had accepted the findings of the Spens Committee and would incorporate them in the new terms of service.

Subsequently the Government submitted the draft terms of service for hospital staff, which, although following the recommendations of the Consultant Spens Committee, applied to them the same betterment factor as was given to general practitioners (20 per cent). This betterment factor of 20 per cent was not accepted by the profession as being an adequate or realistic adjustment of the 1939 figures to post-war conditions, and as early as January, 1949, a deputation from the Joint Consultants Committee and the General Medical Services Committee made joint representations to the Ministry on the subject. The Ministry's attitude at that time was wholly influenced by the White Paper on National Expenditure, and it declined to make any upward adjustment to the betterment factor.

In July, 1949, following discussions on the terms and conditions of service for hospital medical staff, the Joint Committee received certain assurances from the Ministry, among which were the following:—

1. That no changes would be made in the terms and conditions of service without discussions in the appropriate part of the Whitley machinery;
2. That remuneration was regarded as a subject suitable for arbitration; and
3. That save in exceptional circumstances, and after the conciliation machinery of Whitley had been exhausted, issues of remuneration remaining in dispute would go either to arbitration or for inquiry and report by a committee.

Thereupon the Joint Committee advised hospital staff to accept permanent contracts on the basis of the terms and conditions of service then offered.

Meanwhile there was growing unrest amongst general practitioners about the inadequacy of the capitation fee, and after prolonged negotiations the Ministry in October, 1951, agreed to refer the question of the size of the Central Pool

to arbitration, on the understanding that whatever the result of the arbitration might be no additional moneys would be paid unless agreement was reached upon a redistribution of the Central Pool.

Mr. Justice Danckwerts was appointed adjudicator, and his award was published in March, 1952.

A Claim Submitted

In June, 1952—shortly before Parliament approved the necessary Supplementary Estimate to implement the Danckwerts award—the Staff Side notified the Management Side of Committee "B" of its intention to submit a claim for increased betterment for hospital medical staff in the light of the Danckwerts award.

At the outset of negotiations, and before detailed discussion had begun, the attention of the Staff Side was directed to the following statement by the Chancellor of the Exchequer in the House of Commons on 2nd July, 1952:

"I want to make it clear that the terms of reference of Mr. Justice Danckwerts' award were confined solely to the question of the remuneration of general practitioners in the National Health Service and his award has no wider application. In accepting the results of the adjudication, which was of an exceptional nature, the Government have by no means adopted the view that similar adjustments in other fields should follow. In their view there is no justification for any assumption that the appropriate standard of remuneration for the professional classes is a rate of 100 per cent above that in force in 1939. They consider that remuneration should be determined in the light of all relevant circumstances."

The Staff Side was left in no uncertainty as to the Government's policy in the matter, and the attitude of the Management Side. It was quite clear that in no circumstances could a claim be considered for hospital staff based on the Danckwerts award, nor could there be any agreement to submit any such claim to arbitration.

Legal Advice Sought

At this stage the Staff Side decided to take legal advice and consulted Mr. F. Grant, Q.C., who had presented the general practitioners' claim at the Danckwerts adjudication. Amongst other things Mr. Grant was asked whether there were arguments to support a legal claim that the Minister's promise to implement the recommendations of the Spens Committee was implicit in the contracts which consultants had accepted with hospital boards. After studying all the available files, records of past meetings with the Ministry, and other relevant documents, Mr. Grant reached the conclusion that the Staff Side had no claim which was enforceable at law. He did not think that it could be argued that an undertaking by the Ministry to implement the terms of Consultant Spens Report was a part of the contract on which consultants entered the Service. But even if it could be so argued the Minister could claim that the terms of the contract also included an agreement between the Minister and the consultants' representatives that a dispute about outstanding matters concerning the terms and conditions of service should be referred either to arbitration or to a committee of inquiry.

In view of the Government's known attitude towards arbitration, Mr. Grant pointed out that if negotiations broke down in Whitley the Minister could fulfil his undertaking by referring all aspects of consultant remuneration to a committee of enquiry. The results of such an inquiry could not be foreseen, but one danger was that the findings could in effect replace the Spens Report as the basis of consultant remuneration for the future.

Basis of Claim

During the course of negotiations it became clear that, while there was no question of departing from the Chancellor's statement on the application of the Danckwerts award, there seemed to be a realisation that the balance between general practitioner and consultant remuneration had been disturbed, that this factor alone might have an adverse effect on the future recruitment of hospital

staff, and that a claim based on such considerations might well form a basis for discussion and possibly agreement. Thus the Staff Side was faced with two alternatives: either, despite the Chancellor's statement, to press its claim for a strict application of the Danckwerts betterment, or to examine the increases which general practitioners had in fact received as a result of the Danckwerts award, and to see how far these had disturbed the balance of remuneration.

After very careful consideration the Staff Side reached the conclusion that it had very little choice in the matter. The Government, it was clear, had no intention of departing from the Chancellor's statement and the profession in spite of continuous pressure has still been denied the right of unilateral arbitration. Again, because of the different methods of remuneration in general practice and consultant practice, a straightforward application of the Danckwerts "betterment" of 100 per cent to the "Spens salaries" would have meant that a consultant aged 32 would start at £3,000 per annum and rise automatically to £5,000. Again, a consultant holding an A merit award would receive £10,000. Apart from the fact that a claim of this magnitude would have been totally unacceptable to the Management Side the effect would be again to upset the balance of remuneration between the two branches of the profession.

There were also the inescapable facts that the Government acceptance of the Danckwerts award had been conditional upon an agreed redistribution of general practitioner income, and that the effect of the award, coupled with the redistribution scheme, had *not* been to increase the remuneration of *individual* general practitioners by 100 per cent. For all these reasons the Staff Side considered that the only practicable course was to examine the effects of the Danckwerts award in the general practitioner field and to relate them to the position of hospital staffs.

It accordingly looked at the percentage increases of remuneration received by general practitioners with varying sized lists, in order to compare them—so far as it was possible to do so—with hospital staff at different levels on the salary scales. Of necessity the comparison could not be precise because of the fundamental differences in the two methods of remuneration.

In the general practitioner field the effect of Danckwerts had been that the most financially successful general practitioners, with the largest lists, gained virtually no increase of income; again, at the other end of the scale practitioners with very small lists received only a small percentage increase. Practitioners with medium-sized lists, on the other hand, received the greatest benefit from the award.

It proved far from easy to translate the comparison into salary increases for hospital staff. The Staff Side felt, however, that, as in the case of general practitioners, if recruitment to the hospital service was not to be affected the major benefit must be applied to the basic consultant grade in which the majority of hospital staff would make their permanent career rather than to the highest grades in which, in any case, taxation would largely nullify the effect of any increase, or to the lower grades in which most practitioners would not expect to have their permanent career.

Whole-time Consultants

The Staff Side had for some time been pressing the Management Side to review the position of whole-time consultants in the light of the recommendation of the Spens Committee that, in addition to their salary, consultants should receive allowances to cover the expenses reasonably incurred by them in connexion with their duties (e.g., car, telephone, membership of learned societies, and purchase of necessary textbooks). Few of these expenses had been met under the terms and conditions of service, and none of them adequately, and it was the intention of the Staff Side that in the claim for increased remuneration the opportunity should be taken of meeting the just grievances of the whole-time consultant.

The solution proposed to the Staff Side for meeting the whole-time consultant's difficulties was that as part-time consultants and S.H.M.O.s were enjoying disproportionate advantages in the calculation of their salaries the weighting of sessions should be entirely abandoned, all future part-time consultants and

S.H.M.O.s and existing part-time men on promotion to a higher scale being paid unweighted elevenths of the full-time scale.

Apart from the fact that a proposal of this nature would not result in any addition to the whole-time scale, but merely a relative advantage at the expense of his part-time colleagues, the Staff Side felt that it would involve an abandonment of one of the vital principles of the Spens Report to which it could in no circumstances agree. After a very long discussion, the Staff Side agreed that a case had been made for modifying the Spens weighting which at 5 and 6 sessions rises to $1\frac{1}{4}$ elevenths, and that a ceiling of $\frac{1}{4}$ eleventh for weighting should in future be applied. Existing hospital officers would, however, be fully protected against any loss of salary.

Pressure will continue to be exerted on the Management Side to improve the allowances for whole-time consultants.

The Spens Report

The Staff Side is satisfied that the settlement it has achieved does in fact restore the balance between consultant and general-practitioner remuneration which was upset by the Danckwerts award. The differential increases now to be enjoyed by members of hospital staff are a result of a new system of distribution and are no more a departure from the Consultant Spens Report than were the differential increases enjoyed by general practitioners as a result of their new distribution scheme a departure from the General Practitioner Spens Report. In the face of strong pressure to have it abolished the principle of weighting for part-time consultants has been retained. The small modification agreed is but a part of the general redistribution of incomes.

The Staff Side is therefore satisfied that the agreement it has made with the Management Side in no way weakens the Spens Report as the basis of consultant remuneration. In its view Spens remains the yardstick of consultant remuneration and either Side of Committee "B" is free to seek future adjustments in any grade, if experience shows that the present settlement is working unfairly.

Consultation with the Profession

The Staff Side confidently hopes that hospital staffs will regard these increases as satisfactory. Consultants and other members of hospital staffs are, however, entitled to know why it was not found possible to consult them upon the outcome of the negotiations before agreement was reached. This is a difficulty which must always be faced when major issues are at stake. It is implicit in the Whitley machinery that representatives of both Sides have authority to negotiate and eventually to reach agreement. Failure to reach a settlement in Whitley without reference to the profession would undoubtedly have led to the appointment of a committee of inquiry into the question of hospital staff remuneration in all its aspects. This would have delayed a settlement for a very long time and would not necessarily have led to a final agreement better than the one now reached. Moreover, the Staff Side was told that, as an inquiry would probably follow any breakdown in negotiations, it was impossible for the proposed terms of a settlement to be made public, because, if they were rejected, the position of one or other party to the inquiry would be severely prejudiced.

Full consultation with the profession even had it been possible would therefore have meant interminable delays and possibly a hardening of the Government's views. Again, the Staff Side was informed that one of the bodies represented upon it, the Central Consultants and Specialists Committee of the British Medical Association, had in July, 1953, passed the following resolution:

That the Central Consultants and Specialists Committee expresses its appreciation of the efforts of the Staff Side of Committee "B", and of the Central Committee's representatives on the Staff Side, in the matter of the remuneration of hospital medical staffs, and gives such representatives full authority to agree, should they think fit, to such terms as the Staff Side can obtain; provided always that the principles embodied in the Report of the Consultant Spens Committee are maintained, and that the Committee's representatives will act without further reference to this Committee only in case of necessity.

The Staff Side, being satisfied that its negotiations had safeguarded Spens and knowing that it could not refer the terms of the settlement to its constituent bodies, none the less feels confident that the profession will agree that it took the right course in reaching agreement on the new increases. It realises that hospital staffs will be disappointed to find the increases in remuneration are not retrospective, but the Staff Side was convinced that insistence on retrospective application would have led to a complete breakdown in negotiations.

The Staff Side's task over the past 18 months has been far from easy. It has had to press its claim during a period of national retrenchment and in the face of the Government's declared policy on the implications of the Danckwerts award. Only experience can show how far the increases obtained will improve recruitment in the hospital field, but in all the circumstances the Staff Side is satisfied that hospital staffs will welcome them as a reasonable adjustment to the position as it exists today.

APPENDIX E
REMUNERATION OF PART-TIME SPECIALISTS

CONSULTANTS					Senior Hospital Medical Officers			
Number of notional half-days	Fraction of whole-time salary payable (including "weighting")	Minimum point on basic scale (no Distinction Award)	Maximum point on basic scale (no Distinction Award)	Maximum Salaries including Distinction Awards			Salary at minimum point in scale	Salary at maximum point in scale
				with £500 award	with £1,500 award	with £2,500 award		
Whole-time	11/11ths	£ 2,205	£ 3,255	£ 3,755	£ 4,555	£ 5,455	£ 1,654	£ 2,126
1	14/11ths	251	370	427	518	620	188	242
2	24/11ths	501	740	853	1,035	1,240	376	483
3	34/11ths	752	1,110	1,280	1,553	1,860	564	725
4	44/11ths	952	1,406	1,621	1,967	2,356	714	918
5	54/11ths	1,153	1,701	1,963	2,381	2,851	864	1,111
6	64/11ths	1,353	1,997	2,304	2,795	3,347	1,015	1,305
7	74/11ths	1,554	2,293	2,646	3,209	3,843	1,165	1,498
8	84/11ths	1,754	2,589	2,987	3,623	4,339	1,315	1,691
9	94/11ths	1,904	2,811	3,243	3,934	4,711	1,428	1,836

N.B.—All figures on this table are accurate to the nearest pound only.

APPENDIX F

MEDICAL SUPERINTENDENTS IN ENGLAND AND WALES

1. Medical Superintendents graded as Consultants or Senior Hospital Medical Officers who are normally engaged for at least 32 hours per week in clinical work are remunerated as if the whole of their duties were clinical.

2. The salaries of whole-time Medical Superintendents engaged wholly in administrative duties are related to the pointing system in (i) below in the manner indicated in (ii) below.

(i) Pointing System

- (a) For each separate hospital, etc., with 30 or more beds 1 point.
- (b) For each separate hospital, etc., with beds but with less than 30 beds $\frac{1}{2}$ point.
- (c) For each local authority institution containing sick beds for the care of those patients the Hospital Management Committee is responsible $\frac{1}{2}$ point.

The maximum number of points to be awarded under (a), (b) and (c) together is 20 points.

- (d) For each 100 beds (or part of 100 exceeding 50) in institutions for the chronic sick, convalescent homes, tuberculosis sanatoria, isolation hospitals (including smallpox), mental hospitals and mental deficiency institutions, except institutions or hospitals also containing accommodation used by a local authority for the purposes of the National Assistance Act (for which see (f) below) 2 points.
- (e) For each 100 beds (or part of 100 exceeding 50) in other hospitals (general, special, or maternity except institutions or hospitals also containing accommodation used by a local authority for the purposes of the National Assistance Act (for which see (f) below)) 3 points.

- (f) (i) Where part of the accommodation in a hospital vested in the Minister is used by a local authority for the purposes of the National Assistance Act—

For each 100 sick beds (or part of 100 exceeding 50) 2 or 3 points according to the type of beds as in (d) or (e) above.

For each 100 non-sick beds (or part of 100 exceeding 50) 1 point.

- (ii) Where a Hospital Management Committee is responsible for the maintenance, general servicing and lay administration of a special school for children attached to a hospital not vested in the Minister—

For each 100 school beds (or part of 100 exceeding 50) 1 point.

- (iii) Where a Hospital Management Committee is responsible for the care of patients in sick beds in an institution which belongs to a local authority—

For each 100 sick beds (or part of 100 exceeding 50) 1 point.

For non-sick beds No points.

- (g) For each 100 beds (or part of 100 exceeding 50) in reception centres (formerly casual wards) attached to a hospital and administered by the officers of the Hospital Management Committee on behalf of the National Assistance Board 1 point.
- (h) For each 100 cots (or part of 100 exceeding 50) in maternity hospitals or maternity wards of general hospitals 1 point.

Beds are counted according to the system current in the period concerned for counting beds to determine the remuneration of Secretaries of Hospital Management Committees.

(ii) *Salaries*

<i>Points</i>	<i>Salary Scale</i>
Not exceeding 10	£1,500 × £50—£1,700
Exceeding 10 but not exceeding 20	£1,600 × £50—£1,800
Exceeding 20	£1,700 × £50—£1,900

Where the total number of beds in the hospital or hospitals for which the Medical Superintendent is responsible is not more than 100, he receives a flat rate salary of £1,350.

3. A whole-time-Medical Superintendent whose duties are partly clinical and partly administrative and who is not covered by paragraph 2 above is remunerated on the following basis:—

Where x is the number of hours occupied per week in clinical duties he receives:

$\frac{x}{38\frac{1}{2}}$ of the salary he would receive (under paragraphs 1-4 of the Terms and Conditions of Service) if his duties were wholly clinical *plus*

$\frac{38\frac{1}{2}-x}{38\frac{1}{2}}$ of the salary he would receive (under paragraph 3 above) if his duties were wholly administrative.

APPENDIX G

RULES FOR PAYMENT OF DISTINCTION AWARDS TO CLINICAL TEACHERS

1. (a) Holders of whole-time clinical posts in medical or dental schools, or with the Medical Research Council, and
- (b) Teachers (including part-time clinical professors or heads of university clinical departments) who devote a large portion of their time to university work,

with honorary hospital appointments with the appropriate hospital in the grade of consultant are eligible for distinction awards and when given one payment is made on the following basis:—

- (a) Whole-time clinical teachers and research workers (excluding any who are exceptionally permitted to engage in private practice and to retain the fees therefrom or to receive a consolidated sum in return for handing these fees to their employer):—

If their clinical work occupies on an average the following number of hours per week	They should receive the following proportion of any distinction award made to them
21 or more	The full amount
17½ or more but less than 21 ...	4/5ths
14 or more but less than 17½ ...	13/20ths
10½ or more but less than 14 ...	½
7 or more but less than 10½ ...	7/20ths
3½ or more but less than 7 ...	¼
an assessable amount of clinical work, but less than 3½ hours	3/30ths

- (b) Part-time clinical teachers (and whole-time clinical teachers who are exceptionally permitted to engage in private practice and to retain fees therefrom or to receive a consolidated sum in return for handing these fees to their employer):—

These are paid fractions of any awards made to them on the same basis as part-time clinicians, according to the amount of time spent on clinical work, subject to a maximum payment of $9\frac{1}{2}/11$ of the full amount of the award. (See paragraph 41 of the memorandum).

APPENDIX H

OUTLINE OF THE PROVISIONS COVERING PAYMENT OF EXPENSES TO HOSPITAL MEDICAL AND DENTAL STAFF

1. *Travelling Expenses and Mileage Allowances*

(When an officer travels by public transport the actual cost of his journey is reimbursed; when he uses his own car he receives a mileage allowance.)

The rules governing the payment of travelling expenses and mileage allowances for part-time and whole-time medical staff are different; whole-time medical staff are not usually paid expenses for home to hospital journeys whereas part-time officers are.

(a) *Part-Time Officers*

Travelling expenses or mileage allowances are paid for journeys between home or consulting room (whichever is nearer) and any hospital provided that no expenses are paid for any journey or part of a journey which would have been made by the officer irrespective of his employment in the Hospital Service. Payment for journeys to and from the hospital at which the doctor's main duties lie is limited to 10 miles each way unless circumstances warrant exceptional treatment.

(b) *Whole-Time Officers*

- (i) Travelling expenses are reimbursed for journeys between hospitals and for other official journeys up to an amount not exceeding the cost of travelling between the main hospital and the place visited.
- (ii) Mileage allowances are not normally payable for journeys between the hospital at which the doctor's main duties lie and his home. If, however, the doctor has to have his car with him in order to carry out his duties he can, under certain circumstances, claim a mileage allowance (abated by 2d. a mile if he is not a season ticket holder) for his journeys to and from his main hospital subject to a maximum of 10 miles each way. A mileage allowance is paid for journeys direct to a subsidiary hospital subject to a maximum of what would have been payable had the journey been via the main hospital. These arrangements are the same as those applying to other hospital staff.

Class of Travel

Medical staff down to and including registrars are entitled to first class travel, and senior house officers and house officers to second class travel.

Rates of Mileage Allowances

The rates are the same as for all other hospital staff. They are as follows:—

For cars up to and including 10 h.p.

7½d. per mile for the first 2,000 miles per year.

6d. per mile for 2,001–7,000 miles per year.

4½d. per mile thereafter.

Cars over 10 h.p.

9½d. per mile for the first 2,000 miles per year.

7½d. per mile for 2,001–7,000 miles per year.

5½d. per mile thereafter.

These rates do not apply if an officer uses his own car in circumstances where travel by public service would be appropriate. For such journeys a mileage allowance at the rate of 2d. per mile is paid irrespective of the type of vehicle.

2. *Subsistence Allowances*

Medical officers are entitled to subsistence allowances when absent on official business for more than five hours from their normal place of work. The rates of payment are the same as those for other hospital staff; they are:—

For officers in receipt of a salary of £925 per annum or more:—

Absences for more than 5 hours—5s. 0d.

Absences for more than 8 hours—11s. 3d.

Overnight absences—45s. per night for the first 7 nights at one place and 36s. per night for the next 21 nights there.

Officers in receipt of a salary of less than £925 per annum:—

Absences for more than 5 hours—4s. 0d.

Absences for more than 8 hours—9s. 0d.

Overnight absences—36s. per night for the first 7 nights at one place and 29s. per night for the next 21 nights there.

If the absence is at another hospital, these allowances may be modified or none be payable according to the circumstances.

The higher rate is paid after 10 hours' absence to those officers, including doctors, who work regularly away from their headquarters.

3. *Postage and Telephones*

Any expenditure necessarily incurred by an officer on postage and telephone calls in connection with his duties in the hospital service is reimbursed.

It is assumed that normally a doctor will have a telephone, but if he does not and it is essential for the efficiency of the hospital service that he should be on call outside the normal hours of duty and the telephone is the only practical method of communicating with him, the cost of installation and the rental of a telephone at his home may be paid if his salary does not exceed £925 per annum. This arrangement applies to other staff besides doctors.

Alternatively, in the same circumstances, if the officer's residence or quarters are near to the hospital the installation and rental of an extension telephone from the hospital switchboard can be borne by the Board. There is no salary limit to this arrangement which also applies to everyone in the hospital service.

4. *Expenses incurred in attending interviews for appointment*

Any doctor already in any branch of the Health Service who applies for another post in the Service is entitled to receive travelling and subsistence allowances appropriate to his existing salary in respect of expenses incurred in attending for an interview in connection with his application unless he refuses to accept the appointment as advertised.

5. *Dentists*

The foregoing provisions also apply to hospital dental staff.

APPENDIX I

OUTLINE OF THE PROVISIONS RELATING TO ANNUAL, SICK, STUDY AND SPECIAL LEAVE OF HOSPITAL MEDICAL AND DENTAL STAFF

1. *Annual Leave*

- (a) All hospital medical and dental staff with the exception of house officers and locums are entitled to annual leave at the rate of either four or six weeks per year depending upon their annual salary. Those receiving £1,050 or more per annum are entitled to six weeks' leave while those earning less are entitled to four weeks. The leave allowance of part-time officers is based not on their actual salaries but on the whole-time equivalent.

- (b) House officers are entitled to two weeks' leave in respect of each six months' appointment held.
- (c) *Locum tenens*. Practitioners acting as locums in the grades of Senior Registrar and above are entitled to three weeks' leave per six calendar months of continuous locum service and practitioners acting as locums in other grades are entitled to two weeks per six calendar months. No leave can be taken unless the practitioner has completed at least six months' continuous locum service for one or more Boards.
- (d) In addition to their annual leave officers are allowed statutory and other national holidays (or days in lieu).

2. Sick Leave

Officers absent from their duty owing to illness are entitled to receive an allowance in accordance with the following scale:—

During the first year of service:

One month's full pay and (after completing four months' service) two months' half pay.

During the second year of service:

Two months' full pay and two months' half pay.

During the third year of service:

Three months' full pay and three months' half pay.

During the fourth to sixth years of service:

Four months' full pay and four months' half pay.

During the seventh to tenth years of service:

Five months' full pay and five months' half pay.

After completing ten years of service:

Six months' full pay and six months' half pay.

Boards have discretion to extend the application of the scale of allowances in exceptional cases.

3. *Study leave* may be granted for the purpose of study, research, teaching, examining, taking examinations, visiting clinics or attending meetings or conferences of a wholly scientific or clinical character. During study leave an officer must not undertake remunerative work without the permission of the authority granting such leave.

Boards may grant up to thirteen weeks' leave with or without pay subject where leave with pay is granted, to half the period in excess of three weeks being counted against the officer's annual leave allowance. For this purpose an officer may be allowed to carry forward annual leave not exceeding three weeks from the preceding leave year. Expenses may also be paid at the Board's discretion for periods of up to thirteen weeks.

For periods exceeding thirteen weeks Boards may allow leave without pay and expenses but if leave with pay either with or without expenses, is to be granted the Board must obtain the Ministry's permission.

No expenses may be paid however where the leave is for the purpose of sitting for an examination.

Only one period of paid study leave is normally granted to any officer in one leave year.

4. *Compassionate leave* with pay of up to three days in normal circumstances and up to six days in cases of special hardship may be granted at the discretion of employing authorities in cases of urgent domestic distress.

5. *Special leave* with or without pay may be granted by employing authorities to medical staff as with other hospital staff. Examples of circumstances in which such leave may be granted, are when an officer is attending Whitley Council meetings or taking part in local government activities or attending for interview for another appointment.

6. *Maternity Leave*. Married women doctors and dentists who are normally entitled to sick leave are also entitled like other hospital staff to maternity leave when they have completed twelve months' continuous service, provided they intend to

continue in the service of the employing authority for at least three months after taking maternity leave. Officers who do not qualify for maternity leave may be granted leave without pay for the confinement and leave without pay may also be allowed in excess of the specified period for officers entitled to normal maternity leave.

The normal entitlement of maternity leave is eighteen weeks. The first four weeks of absence is on full pay subject to the deduction of maternity allowance and any dependant's allowance payable under the maternity benefit scheme and for the remaining fourteen weeks on half pay so long as the total of half pay and maternity and other weekly allowances does not exceed full pay.

APPENDIX J

EXTRACT FROM THE REPORT OF THE COMMITTEE OF ENQUIRY INTO THE COST OF THE NATIONAL HEALTH SERVICE

WHOLE-TIME AND PART-TIME CONSULTANT APPOINTMENTS

398. A good deal of criticism has been voiced—both in the evidence to this Committee and elsewhere—about the disparity between the financial inducements offered under the present terms and conditions of service for part-time consultant appointments in the hospital service, as compared with the basic whole-time rates. In particular, we have been told that the scales are weighted in favour of the part-time consultant by

- (a) the inclusion of travelling time (up to a maximum of $\frac{1}{2}$ hour each way to and from his main hospital) in the *paid sessions* of the part-timer;
- (b) the payment of his travelling expenses to and from home (up to a maximum of ten miles each way);
- (c) the payment for domiciliary visits, at the rate of 4 guineas per visit, up to a maximum of 800 guineas per year. No extra payment is made to the whole-time consultant for any domiciliary visits he may make;⁽¹⁾ and we understand that general practitioners rarely call upon whole-time consultants for this class of work;
- (d) the adjustments made in favour of the part-time consultant, when computing the number of notional half-days on which his salary is reckoned. We understand that the Regional Board first assesses in terms of hours per week what is the average amount of time required by an average practitioner to perform the duties attaching to the part-time post. The total number of hours per week is then converted into notional "half days" per week by dividing them by $3\frac{1}{2}$. If the resulting figure is fractional the consultant is allowed the next highest whole number of half days as follows:—

Number of hours worked per week										Number of notional "half days" on which salary is reckoned
Up to $3\frac{1}{2}$	...	...	...	...	...	...	...	...	...	1
Over $3\frac{1}{2}$	and up to and including	7	...	...	...	...	...	...	...	2
" 7	" " " " "	10 $\frac{1}{2}$	...	...	...	...	...	...	...	3
" 10 $\frac{1}{2}$	" " " " "	14	...	...	...	...	...	...	...	4
" 14	" " " " "	17 $\frac{1}{2}$	...	...	...	...	...	...	...	5
" 17 $\frac{1}{2}$	" " " " "	21	...	...	...	...	...	...	...	6
" 21	" " " " "	24 $\frac{1}{2}$	...	...	...	...	...	...	...	7
" 24 $\frac{1}{2}$	" " " " "	28	...	...	...	...	...	...	...	8
" 28	...	...	...	...	...	...	...	...	...	9

- (e) The weighting made in favour of the part-time consultant appointment, as compared with the whole-time basic rate, in calculating the salary to be paid for the number of notional half days worked.

(¹) We understand, however, that arrangements have recently been made whereby whole-time consultants may, subject to certain conditions, be paid for domiciliary consultations (see H.M. (55) 107).

The table below shows the proportion of the whole-time salary payable in relation to the number of notional half days worked.

Number of notional half days						Proportion of Salary (Expressed as elevenths of the whole-time basic rate)
1	...	...	...	...	...	$1\frac{1}{11}$
2	...	...	...	...	...	$2\frac{2}{11}$
3	...	...	...	...	...	$3\frac{3}{11}$
4	...	...	...	...	...	$4\frac{4}{11}$
5	...	...	...	...	...	$5\frac{5}{11}$
6	...	...	...	...	...	$6\frac{6}{11}$
7	...	...	...	...	...	$7\frac{7}{11}$
8	...	...	...	...	...	$8\frac{8}{11}$
9	...	...	...	...	...	$9\frac{9}{11}$

It will be noted that the "weighting" in favour of the part-time appointment varies from $\frac{1}{11}$ to $\frac{9}{11}$ (expressed in elevenths of the whole-time basic rate) according to the number of notional half days worked. We understand that the weighting is intended to cover time spent on emergency calls and committee work.

399. In addition to these benefits, the part-time consultant is of course able to continue with his private practice outside the National Health Service and also, we understand, enjoys certain advantages in the assessment of his income tax liabilities. Admittedly, these privileges are not connected directly with the consultant's terms and conditions of service, but we mention them because they must clearly form part of the financial inducement which leads individual consultants to decide whether to accept the whole-time or part-time appointment.

400. We have heard differing views about the consequences of these unequal rewards, and about their practical effect. Some have gone so far as to recommend that the part-time appointments should be abolished altogether,⁽¹⁾ and whole-time appointments substituted throughout the whole hospital service. These witnesses have suggested that the part-time consultant must inevitably have a divided loyalty between his private practice and his hospital duties. The whole-time consultant, on the other hand, has no temptation to disregard his hospital duties, and his services cost the Exchequer less per contractual session than those of the part-time consultant. Moreover, if all part-time consultants were to be replaced by whole-time staff, fewer deputies would be required in the service and the demand for junior staff would decrease accordingly. Finally a universal whole-time consultant service would prevent any differences of opinion—which have arisen in the past between the profession and the Regional Hospital Boards—whether a particular appointment should be whole-time or part-time.

401. The majority of our witnesses, however, have favoured the retention of the part-time consultant service and the following are some of the reasons which have been put forward in support of their case:—

- (i) So long as private practice and hospital pay beds continue, provision must be made for part-time consultant appointments in the hospital service.
- (ii) The services of many eminent consultants could only be obtained through a part-time contract.
- (iii) One of the most beneficial results of the National Health Service has been the spread of the consultant services to the remoter areas of the country. This improvement has been due, in some degree, to the provision of consultant services on a part-time as well as a whole-time basis.

(1) This would require an amendment to Section 12 of the National Health Service (Amendment) Act, 1949, which added the following proviso to Section 56 of the 1946 Act and Section 65 of the 1947 Act—"Provided that regulations made under this Section shall not contain any requirement that all specialists employed for the purpose of hospital and specialist services shall be employed whole-time."

- (iv) Emergency medical and surgical cover in hospitals can often be provided more cheaply and effectively by two part-time consultants than by one whole-time consultant.
- (v) Private practice (including not only the treatment of private patients, but also private work on behalf of the Courts, Insurance Companies, etc.) gives the consultant a wider outlook in his work and prevents his becoming too remote from the world outside the hospital.
- (vi) The majority of part-time consultants work longer hours than they have contracted to do. This is particularly true of the part-time consultant who has contracted to do the maximum number of sessions allowed under a part-time contract (i.e. 9 notional half days). We gather that it is the custom of many Boards now to allow the consultant himself to decide, in appropriate cases, whether to accept a whole-time or part-time contract, although the duties will in either event be those of a whole-time appointment. One Board told us that they estimated that their part-time consultants generally were putting in 10 per cent more hours than they had undertaken to do in their contract. (Other witnesses, however, have added that some whole-time consultants also do more than their contractual sessions; and that the amount of work done by a consultant, whether whole-time or part-time, depends more on the personalities involved than on the type of the contract made.)

DISTRIBUTION OF PART-TIME AND WHOLE-TIME CONSULTANTS

402. Table 42 shows the seasonal distribution of part-time consultants in England and Wales at 30th June, 1955, and in Scotland at 31st December, 1954:—

TABLE 42

Seasonal Distribution of Part-time Consultants in England and Wales and Scotland

No. of Sessions (half-days) worked	Percentage of part-time consultants who do the No. of sessions in the first column	
	England and Wales	Scotland
9	58.12	27.2
8	11.58	34.5
7	7.74	23.4
6	5.89	7.6
5	4.49	2.0
4	3.74	2.5
3	3.44	1.5
2	3.13	0.8
1	1.87	0.5
<hr/>		
Average No. of sessions worked by part-time consultants ...	7.65	7.6

It will be observed that the average number of weekly sessions worked by part-time consultants is high, and that in England and Wales the "maximum part-timers" constitute the great majority of part-time consultant appointments (58.12 per cent). It is interesting to note that there is also a stronger tradition of whole-time consultant service in Scotland than in England and Wales. At 31st December, 1954, 45 per cent of the consultants practising in the National Health Service in Scotland held whole-time contracts, whereas the comparable figure for England and Wales at 30th June, 1955, was 32.09 per cent.

Our Own View

403. After carefully considering the many suggestions and views which have been received on this subject, we have concluded that, in the interests of the hospital service, there is a valid case under existing conditions for the retention

of part-time consultant appointments in addition to whole-time appointments. We consider it very desirable, however, that Regional Boards should be free to appoint whole-time consultants in cases where it is deemed to be necessary in the interests of the service. We trust that joint consultation between Regional Boards and the medical consultative committees (to which we have referred in para. 227 of our Report) will lead to agreement between the Boards and the medical profession, and will prevent the emergence of differences of opinion over the conditions of appointment such as have been known to occur in the past.

404. We are also of opinion that it is undesirable that the financial arrangements relating to the consultant service should be such as to provide a financial inducement to a consultant to apply for a part-time rather than a whole-time appointment.

APPENDIX K

NATIONAL HEALTH SERVICE

SPECIALTIES AND CAPACITIES IN WHICH SENIOR HOSPITAL MEDICAL OFFICERS* MAY BE EMPLOYED

1. The extent to which the medical establishments of hospitals should include senior hospital medical officer posts has been discussed with the profession and the following paragraphs embody the agreement which has been reached in the fields in which such posts are appropriate.

Future Appointments to established consultant posts

2. Consultant posts in the medical establishments of hospitals should not be filled by senior hospital medical officers except where, after advertisement, no candidate applies who is regarded as of consultant status by the appropriate Advisory Appointments Committee, but the post cannot be left vacant if the essential needs of the service are to be met.

In these exceptional circumstances, a Board should not offer the vacant appointment to one of the applicants as a senior hospital medical officer post, but should take the following steps:—

- (a) consider whether by a re-arrangement of the duties of the appointment the field of applicants of consultant status could be extended;
- (b) if this course is not practicable or fails to attract candidates of consultant status, the vacancy may be re-advertised as a senior hospital medical officer post.

Appointment of part-time general practitioner to senior hospital medical officer posts

3. Boards should not overlook the possibility that in some specialties general practitioners may be qualified for part-time appointments on the senior hospital medical officer scale—for instance as Assistant Anaesthetists, Assistant Geriatricians, Assistant Paediatricians or as medical officers in charge of small infectious diseases hospitals.

Revision of establishments: effect on existing officers

4. Boards should now proceed to revise their establishments, making proper provision for senior hospital medical officer posts in accordance with the principles set out below. Any such revision should not, however, be allowed to effect the personal status of the officers at present holding a post the status of which is changed as a result of the revision. This means that practitioners personally graded as senior hospital medical officers who are holding consultant posts or those personally graded as consultants holding posts which become senior

* It should be made clear that, although the term "senior hospital medical officer" is used here and elsewhere as a convenient phrase for identifying and describing a particular grade and salary scale, there is every advantage (provided the grade is made clear) in describing the posts concerned in terms of the specialty involved, e.g. Assistant Anaesthetist, Assistant Paediatrician, etc.

hospital medical officer posts should retain their present personal status. When such a post becomes vacant, however, it should be advertised with its revised status, and a new appointment made in accordance with the grading of the post.

5. (a) *Specialties in which establishments should not provide for senior hospital medical officer posts, except in the circumstances set out below (such specialties being marked*)*

*Anaesthetics.

General Medicine.

General Surgery (including urology, proctology, *orthopaedics and *ophthalmology).

Obstetrics and Gynaecology (practised together).

Cardiology.

Dermatology.

Otolaryngology.

Neurology.

Neurosurgery.

*Paediatrics.

*Pathology.

*Psychiatry and Mental Deficiency.

Plastic Surgery.

*Radiology.

Thoracic Surgery.

- (b) *Specialties in which establishments may provide for senior hospital medical officer posts*

These specialties are set out in alphabetical order, specifying in each case the type or types of appointment for which senior hospital medical officer posts are appropriate.

Blood Transfusion

Posts below that of Director of Regional Blood Transfusion Service.

Diseases of the Chest

Posts in a restricted part of this field—e.g. limited to routine tuberculosis dispensary work only; posts as medical officers of sanatoria either in charge of small units or below the rank of superintendent in charge; and posts as assistant to a consultant in charge.

Geriatrics

Posts below the rank of head of a large department; and other posts where the scope for investigation and active treatment of the clinical responsibility is insufficient to justify consultant status.

Infectious Diseases

Medical Superintendents of small hospitals; at other hospitals posts below that rank.

Obstetrics (practised alone)

(1) Posts at ante-natal and post-natal clinics.

(2) Posts in maternity departments which are under the general supervision of a consultant.

Ophthalmology

Posts primarily concerned with non-operative work (e.g. refraction).

Orthopaedics

Posts primarily concerned with non-operative work.

Paediatrics

Posts at welfare centres and other posts primarily concerned with child welfare.

Physical Medicine

Post of officer in charge of a small clinic; in large departments posts other than head of the department.

Psychiatry and Mental Deficiency

- (1) Posts of medical superintendent of small institutions; at larger mental institutions some posts below that rank.
- (2) Posts primarily concerned with limited fields of psychiatry.

Venereal Disease

As for Physical Medicine.

- (c) *Specialties in which establishments may provide for assistantships to consultants remunerated on the S.H.M.O. scale*

Anaesthetics

Hospital establishments should include an adequate complement of widely experienced anaesthetists of consultant status (vide paragraphs 79 to 81 of the pamphlet "Development of Consultant Services").

In addition to this complement of consultants and to trainees, there will often be a need in some hospitals for Assistant Anaesthetists remunerated on the senior hospital medical officer scale.

Pathology

The staff of a pathological department should consist of consultants and trainees as appropriate, with a limited field for the appointment of Assistant Pathologists remunerated on the senior hospital medical officer scale.

The complement of consultants must depend on the size of the department but in any event, where there are separate sections each in the charge of a pathologist under the general control of the head of the department (e.g. morbid anatomy, biochemistry, haematology, bacteriology, blood transfusion) each should be of consultant status.

Radiology and Radiotherapy

The establishment of radiodiagnostic or radiotherapeutic departments should include at least one practitioner of consultant status with trainees as appropriate. Where the complement of consultants and trainees is not sufficient to deal with the work of the department, it may be necessary to appoint Assistant Radiologists of narrower training and with more limited responsibility than the consultant, remunerated on the senior hospital medical officer scale.

Specialties not mentioned above

6. Boards should not establish any consultant or S.H.M.O. post in a specialty not mentioned above without the approval of the Ministry.

APPENDIX L

NUMBERS, BY AGE GROUPS, OF MALE MEDICAL AND DENTAL STUDENTS IN MEDICAL OR DENTAL SCHOOLS IN GREAT BRITAIN LIABLE FOR RECRUITMENT UNDER THE NATIONAL SERVICE ACTS, WHO WERE EXPECTED TO QUALIFY IN EACH OF THE YEARS 1954, 1955 AND 1956.

(Figures supplied from estimates made by Ministry of Labour and National Service in November 1953, 1954 and 1955, respectively)

AGE	MEDICAL			DENTAL		
	<i>Due to qualify</i>			<i>Due to qualify</i>		
	1954	1955	1956	1954	1955	1956
21	—	—	—	1	3	2
22	10	9	16	26	26	23
23	231	219	237	72	90	91
24	341	415	423	60	77	85
25	110	153	249	8	30	52
26	15	28	49	3	4	7
27	6	5	10	—	—	—
28	—	1	2	—	—	2
	—	—	—	—	—	—
	713	830	986	170	230	262
	—	—	—	—	—	—

APPENDIX N

SENIOR REGISTRARS IN ENGLAND AND WALES ON 30TH JUNE, 1956

Senior Registrars who hold posts in more than one specialty have been counted once only

SPECIALITIES	No. of approved training posts	In training posts				Others							Grand Total		
		1st year	2nd year	3rd year	4th year	Total	A	B	C	D	E	F		G	Total
General Medicine	131	32	34	21	25	112	18	3	17	1	5	3	4	51	163
Diseases of the Chest	55	11	14	10	6	41	—	1	—	—	1	—	1	3	44
Mental Health	142	43	26	18	8	95	2	—	1	—	—	8	—	12	107
Neurology	13	2	3	2	5	12	1	—	—	—	1	—	—	2	14
Pædiatrics	28	3	6	4	5	18	3	—	2	—	2	—	2	9	27
Radiology	68	22	12	12	7	53	1	—	—	—	—	—	—	3	56
Radiotherapy	13	3	3	2	3	11	—	—	—	—	—	—	—	—	11
Physical Medicine	13	3	4	2	1	10	—	—	—	—	—	—	—	—	10
Pathology	66	14	11	12	13	50	2	—	21	—	2	—	1	26	76
Infectious Diseases	3	1	1	—	1	3	—	—	1	—	—	—	—	—	4
Dermatology	23	2	3	4	5	14	1	—	2	—	2	1	3	9	23
Venerology	8	1	1	1	1	4	—	—	—	—	1	—	—	2	6
Ophthalmology	45	13	15	9	5	42	4	—	—	—	6	—	1	11	53
General Surgery	138	38	34	24	21	117	30	2	10	5	1	1	7	56	173
Anæsthetics	76	33	15	11	3	62	1	—	2	—	—	—	—	5	67
Neuro-Surgery	12	2	5	1	2	10	—	2	—	—	—	—	1	3	13
Plastic Surgery	15	1	4	2	1	8	3	3	1	—	—	—	—	7	15
Thoracic Surgery	17	5	3	5	2	15	—	2	—	—	4	—	2	10	25
Orthopaedic Surgery	48	19	15	6	4	44	6	—	1	—	1	—	1	9	53
Dentistry	30	6	8	5	6	25	2	—	14	—	—	—	5	21	46
Ear, Nose and Throat Surgery	36	14	5	9	4	32	1	—	1	—	—	2	3	7	39
Obstetrics and Gynaecology	70	13	21	15	8	57	9	—	5	—	6	—	3	25	82
Reserve	5	—	—	—	—	—	—	—	—	—	—	—	—	—	—
TOTALS	1,055	281	243	175	136	835	84	13	78	8	33	17	39	272	1,107

A = Men who have completed 4 years training and are awaiting higher posts (including transitional appointments).

B = Holders of training posts for a 5th or 6th year.

C = University staff with honorary posts.

D = Men from overseas.

E = Part-time S.R.'s, most of whom hold part-time posts as Cons., S.H.M.O.'s, or S.H.D.O.'s.

F = Unlimited tenure. (Persons holding, before July, 1948, hospital posts which were neither of limited tenure or by custom held for a short period only and which were graded as S.R.'s following the inception of the N.H.S.)

G = Others holding posts of a kind not included above but graded as S.R.

SENIOR REGISTRARS IN SCOTLAND ON 30TH JUNE, 1956

SPECIALTIES	No. of up-proved training posts	In training posts					*Other	Grand Total
		1st year	2nd year	3rd year	4th year	Total		
General Medicine ...	24	7	6	9	2	24	17	41
Diseases of the Chest ...	8	1	4	1	2	8	1	9
Mental Health ...	15	6	6	2	1	15	—	15
Neurology ...	—	—	—	—	—	—	—	—
Pædiatrics ...	6	1	2	3	—	6	3	9
Radiology ...	11	3	3	4	1	11	—	11
Radiotherapy ...	5	1	2	2	—	5	—	5
Physical Medicine ...	—	—	—	—	—	—	—	—
Pathology ...	13	2	6	2	3	13	14	27
Infectious Diseases ...	1	1	—	—	—	1	1	2
Dermatology ...	2	—	—	—	2	2	4	6
Venereology ...	—	—	—	—	—	—	—	—
Ophthalmology ...	12	6	3	3	—	12	—	12
General Surgery ...	28	9	7	7	5	28	10	38
Anæsthetics ...	11	6	4	—	1	11	1	12
Neuro-Surgery ...	2	—	1	1	—	2	—	2
Plastic Surgery ...	1	—	—	—	1	1	1	2
Thoracic Surgery ...	4	—	2	1	1	4	—	4
Orthopaedic Surgery ...	10	3	3	2	2	10	2	12
Dentistry ...	3	1	—	1	1	3	1	4
Ear, Nose and Throat Surgery ...	8	3	4	—	1	8	—	8
Obstetrics and Gynaecology ...	10	4	3	2	1	10	9	19
TOTALS ...	174	54	56	40	24	174	*64	238

* These comprise officers holding appointments in the categories described at the foot of Sheet 1 but the numbers in each category are unknown except for category C in which there are 30.

APPENDIX O

YEARS OF QUALIFICATION OF SENIOR REGISTRARS WHO HAD COMPLETED TRAINING BY JUNE, 1956,
AND WERE THEN SEEKING A HIGHER APPOINTMENT
(ENGLAND AND WALES)

SPECIALTY	Pre- 1937	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947	Post- 1947	Total
General Medicine	1	1	2	5	4	1	2	1	1	—	18
Mental Health	—	—	—	—	—	—	1	—	—	—	2
Neurology	—	—	—	—	—	—	1	—	—	—	2
Pediatrics	—	1	—	—	1	1	—	—	—	—	3
Radiology	—	—	—	—	—	—	—	—	1	1	2
Pathology	—	—	—	—	—	—	—	—	—	—	1
Dermatology	—	—	1	—	—	—	—	—	1	1	4
Ophthalmology	1	2	3	8	5	2	3	1	—	—	30
General Surgery	...	3	1	1	—	—	—	—	—	—	—	—	—	5
Anaesthetics	—	—	1	—	—	1	—	—	—	—	3
Plastic Surgery	—	—	1	—	1	—	—	1	—	—	6
Orthopaedic Surgery	2	—	—	—	—	—	—	—	1	—	2
Dentistry	...	1	—	—	—	—	—	—	—	—	—	—	—	1
Ear, Nose and Throat	—	1	—	—	—	—	1	—	—	—	9
Obstetrics and Gynaecology	—	—	—	3	3	—	—	—	—	—	6
TOTALS	...	5	4	2	6	5	8	16	5	9	3	4	3	84

APPENDIX P
HEADQUARTERS MEDICAL STAFF OF REGIONAL HOSPITAL BOARDS

Salary Scales

Grade and Region	Scales up to 30th September, 1950	Scales operative from 1st October, 1950 (Industrial Court Award)	Current scales operative from 1st April, 1955
<i>Senior Administrative Medical Officers</i>			
Four Metropolitan Regions, Birmingham, Liverpool, Manchester, Sheffield and Western Region of Scotland (Sheffield was in the next Group until 1st February, 1953)	£2,500	£2,500 × £150 - £3,250	£2,900 × £140 - £3,600
Bristol, Leeds, Newcastle, Wales and South Eastern Region of Scotland	£2,250	£2,250 × £150 - £3,000	£2,650 × £140 - £3,350
East Anglia and Oxford ...	£2,000	£2,000 × £150 - £2,750	£2,400 × £140 - £3,100
Eastern and North Eastern Regions of Scotland	£1,850	£1,850 × £125 - £2,475	£2,250 × £115 - £2,825
Northern Region of Scotland	£1,750	£1,750 × £100 - £2,250	£2,150 × £90 - £2,600
<i>Deputy Senior Administrative Medical Officers</i>			
Four Metropolitan Regions, Birmingham, Liverpool, Manchester, Sheffield, and Western Region of Scotland (Sheffield was in the next Group until 1st February, 1953)	£1,550 × £50 - £1,750	£1,650 × £100 - £2,150	£1,900 × £100 - £2,400
Bristol, Leeds, Newcastle, Wales and South Eastern Region of Scotland	where the em- ployment of a deputy is specific- ally authorised by the Minister or the Secretary of State, plus a weighting of £50	£1,600 × £100 - £2,100	£1,850 × £100 - £2,350
East Anglia and Oxford ...	for officers em- ployed in the Metropolitan Area	£1,550 × £100 - £2,050	£1,800 × £100 - £2,300
<i>Assistant Senior Medical Officers*</i>			
All Regions except those mentioned below	£1,450 × £50 - £1,650	£1,500 × £75 × £100 - £1,900	£1,680 × £80 (4) × £100 (1) - £2,100
Eastern, North Eastern and Northern Regions of Scot- land	-	£1,500 × £75 - £1,800	£1,680 × £80 - £2,000
<i>Medical Officers* (at age 33 or over)</i>			
(i) All Regions ...	£1,100 × £30 (5) × £50 (4) - £1,450	£1,250 × £50 - £1,500	£1,415 × £50 (4) × £65 (1) - £1,680
(ii) If in exceptional circum- stances, these officers are appointed below the age of 33, their salaries shall be as follows:—			
at age 32 ...	—	—	£1,375
at age 31 ...	—	—	£1,335
at age 30 ...	—	—	£1,295
at age 29 or less ...	—	—	£1,275

* (Note: Officers in these grades employed in the Metropolitan Police Area shall receive a London weighting allowance of £50 per annum.)

APPENDIX P—continued

Grade and Region	Scales up to 30th September, 1950	Scales operative from 1st October, 1950 (Industrial Court Award)	Current scales operative from 1st April, 1955
<i>Regional Psychiatrists</i>			
Four Metropolitan Regions, Birmingham, Liverpool and Manchester Regions	£2,000	$£2,000 \times £125 =$ £2,625	$£2,400 \times £115 =$ £2,975
Bristol, Leeds, Newcastle, Sheffield and Welsh Regions	£1,900	$£1,900 \times £125 =$ £2,525	$£2,300 \times £115 =$ £2,875
East Anglia and Oxford Regions	£1,800	$£1,800 \times £125 =$ £2,425	$£2,200 \times £115 =$ £2,775

These scales relate to officers engaged wholly on administrative duties as Regional Psychiatrists. Where a whole-time officer is appointed on the basis that he will devote part of his time to administrative work as a Regional Psychiatrist and the remainder of his time to clinical work as a member of the clinical staff of a hospital, his total remuneration shall be the aggregate of the respective unweighted proportions of the above-mentioned salary (for the administrative work) and of the whole-time clinical salary appropriate to his professional status as a clinician (for the clinical work).

APPENDIX Q

SHEET 1

NUMBER OF DOCTORS PROVIDING GENERAL MEDICAL SERVICES
(England and Wales)

	1st July, 1952	1st July, 1953	1st July, 1954	1st July, 1955	1st July, 1956
I. Single-handed practitioners	7,459	7,147	6,899	6,715	6,568
Members of partnerships of—					
2 doctors	5,732	6,146	6,414	6,628	6,728
3 doctors	2,577	2,898	3,129	3,246	3,465
4 doctors	960	1,168	1,308	1,440	1,528
5 doctors	315	410	445	465	460
6 or more doctors	161	241	287	289	333
Section I—Total	17,204	18,010	18,482	18,783	19,082
II. Members of mixed partnerships ...	15	8	8	11	13
Practitioners residing in the "fringe" area with Scotland	25	26	25	25	25
Members of partnerships providing general medical services where one or more partners provide maternity medical services only	10	6	4	5	13
Members of partnerships providing unrestricted services where one or more partners have limited lists ...	14	9	9	8	12
Section II—Total	64	49	46	49	63
III. Single-handed practitioners:—					
(a) providing restricted services at hospitals, etc.	764	732	723	707	697
(b) other reasons	46	33	34	25	25
Members of partnerships:—					
(a) providing restricted services at hospitals, etc.	16	12	11	11	11
(b) other reasons	2	3	4	3	3
Section III—Total	828	780	772	753	743
Sections I, II and III—GRAND TOTAL ...	18,096	18,839	19,300	19,585	19,888
IV. Principals providing maternity medical services only	68	69	65	57	63
Sections I, II, III and IV—GRAND TOTAL ...	18,164	18,908	19,365	19,642	19,951
ASSISTANTS					
"Permanent" assistants	1,689	1,596	1,504	1,515	1,546
Trainee assistants	369	297	296	504	368
TOTAL ASSISTANTS	2,058	1,893	1,800	1,819	1,914

NUMBER OF DOCTORS PROVIDING GENERAL MEDICAL SERVICES
(Scotland)

	1st July, 1952	1st July, 1953	1st July, 1954	1st July, 1955	1st July, 1956
PRINCIPALS					
I. Single-handed practitioners	1,085	1,038	1,003	971	935
Members of partnerships of—					
2 doctors	857	921	920	912	951
3 doctors	293	349	379	430	456
4 doctors	88	92	132	148	148
5 doctors	25	30	30	30	35
6 or more doctors	6	12	18	24	24
Section I—Total	2,354	2,442	2,482	2,515	2,549
II. Principals also acting as assistants ...	23	17	16	9	9
III. Principals providing restricted general medical services	44	44	44	42	40
Sections I, II and III—GRAND TOTAL ...	2,421	2,503	2,542	2,566	2,598
IV. Principals providing maternity medical services only	3	2	2	2	2
Sections I, II, III and IV—GRAND TOTAL ...	2,424	2,505	2,544	2,568	2,600
ASSISTANTS					
Assistants (other than those who are also principals and trainee assistants)	274	275	257	258	249
Trainee Assistants	99	96	88	103	87
TOTAL ASSISTANTS	373	371	345	361	336

NOTE:

The total number of doctors in each partnership category at I above is not always an exact multiple of the number in the partnership, since some partnerships include doctors shown elsewhere in the table.

APPENDIX R

**GENERAL MEDICAL PRACTITIONERS CLASSIFIED ACCORDING TO AGE
AND SIZE OF LIST (AS AT 1st JULY, 1956)**

AGE	Number of Patients				TOTAL
	Under 1,501	1,501–2,500	2,501–3,600	3,601 and over	
		<i>England and Wales</i>			
35 and under	2,133	886	582	200	3,801
36–45	1,303	1,546	1,807	927	5,583
46–55	764	1,339	1,709	1,153	4,965
56–65	734	1,072	1,046	618	3,470
66 and over	566	375	241	81	1,263
		<i>Scotland</i>			
All ages	783	1,207	489	105	2,584

APPENDIX S

ANALYSIS OF SALARIES (INCLUDING CAR ALLOWANCES) OFFERED TO ASSISTANTS: BRITISH MEDICAL JOURNAL

	1952-53	1954-55	1955-56	1956-57
<i>Salary offered</i> £	Per cent of total number of cases			
700	0.5	—	2.5	—
750	3.3	—	—	—
800	1.9	1.0	—	0.5
850	3.8	0.5	—	1.0
900	2.9	10.0	4.4	4.6
950	3.8	5.7	3.1	3.6
1,000	46.2	40.9	50.6	39.5
1,050	9.5	5.2	6.9	12.3
1,100	15.7	15.2	11.9	15.4
1,150	4.8	10.5	6.9	11.8
1,200	5.7	5.7	11.9	9.8
1,250	1.9	1.9	1.2	—
1,300	—	1.0	0.6	1.5
1,350	—	1.9	—	—
1,400	—	0.5	—	—
TOTAL ...	100.0	100.0	100.0	100.0
Number of cases included ...	210	210	160	195

APPENDIX T

GENERAL MEDICAL PRACTITIONERS' ASSISTANTS BECOMING PRINCIPALS (ENGLAND AND WALES)

Age	Year ending 1st July, 1955		Year ending 1st July, 1956	
	No.	Per cent of total	No.	Per cent of total
30 and under ...	208	39.9	178	37.3
31-35 ...	215	41.3	205	43.0
36-40 ...	57	10.9	62	13.0
41-45 ...	24	4.6	21	4.4
46-50 ...	7	1.3	4	0.8
51-55 ...	4	0.8	5	1.1
56-60 ...	6	1.2	1	0.2
61-65 ...	—	0	1	0.2
TOTALS ...	521	100.0%	477	100.0%

APPENDIX U

AGES OF DENTAL PRACTITIONERS WHO BECAME PRINCIPALS IN 1956
(ENGLAND AND WALES)

Age	Number of Dentists	Age	Number of Dentists
22	5	47	1
23	10	48	—
24	3	49	—
25	13	50	1
26	13	51	—
27	27	52	—
28	34	53	1
29	18	54	2
30	20	55	—
31	13	56	1
32	9	57	1
33	13	58	1
34	5	59	—
35	4	60	—
36	3	61	—
37	5	62	1
38	4	63	1
39	3	64	1
40	—	65	1
41	—	66	1
42	1	67	—
43	2	68	—
44	—	69	1
45	1	Not known	11
46	1		
		Total	232

DENTAL TECHNICIANS (Note 1)

Grade	1.5.49 (Note 3)		3.9.51		1.3.53		1.9.55		1.1.57	
	Scale	Per-centage increase	Scale	Per-centage increase	Scale	Per-centage increase	Scale	Per-centage increase	Scale	Per-centage increase
Chief Technician (14 or more staff)	£ 480 × 20–620	4·5	£ 505 × 20–645	4·5	£ 530 × 20–670	4·3	£ 575 × 20 (6)–695 × 25 (1)–720	7·9	£ 605 × 20 (4)–685 × 25 (3)–760	5·5
Chief Technician (6–13 staff)	430 × 15–490 × 20–550	5·1	455 × 15–515 × 20–575	5·1	480 × 15–540 × 20–600	4·9	520 × 15 (3)–565 × 20 (4)–645	7·9	545 × 15 (2)–575 × 20 (5)–675	4·7
Senior Technician	400 × 15–490	5·6	425 × 15–515	5·6	450 × 15–540	5·3	485 × 15 (4)–545 × 20 (2)–585	8·1	510 × 15 (3)–555 × 20 (3)–615	5·1
Technician ...	340 × 10–360 × 15–420	6·6	360 × 15–450	6·6	380 × 15–470	4·9	410 × 15 (4)–470 × 20 (2)–510	8·2	430 × 15 (3)–475 × 20 (3)–535	4·9

NOTES:

- There are seven grades of staff in this class (excluding apprentices). Those in the table are representative grades.
- There is no information about the rates paid pre-war. At the inception of the National Health Service, there were no negotiated rates for dental technicians employed in hospitals but it is believed that some hospitals were guided by the salaries negotiated for other dental technicians by the National Joint Council; these were *minimum* rates of £8 per week for Grade I (roughly equivalent to the present Senior grade) and £6 10s. per week for Grade II (roughly equivalent to the present Technician grade).
- These are the first N.H.S. Whitley Council scales.
- All increases given were to take account of changes in economic circumstances. The percentage increases above are calculated on the means of successive scales.
- Qualifications.* None are specified but five years' apprenticeship is normally served by new entrants to the class.
- Hours of duty; overtime.* Normal hours are 39 per week exclusive of meal times. For extra hours worked time-off in lieu is given when possible but where this is not possible overtime is paid to certain of the junior grades at plain time rates up to 10 hours and at time-and-a-quarter over 10 hours.
- Annual leave.* 12–21 working days according to grade and, in the case of apprentices, age.
- Protective clothing* is provided and laundered by the employing authority.
- There is no Whitley agreement on charges for meals but employing authorities would base them on the cost of the services provided.

APPENDIX V—continued
MEDICAL AUXILIARIES (Note 1)

Grade	Scales at 5.7.48 (Note 2)	Scales (at dates shown)	Per- centage increase	Scales (at dates shown)	Per- centage increase	Scales (at dates shown)	Per- centage increase
<i>Physiotherapist</i> Superintendent	£ 470 × 15-560	£ 1.4.51 520 × 15-610	9.7	£ 1.5.52 590 × 20-690	13.3	£ 1.12.54 615 × 20-715	3.9
Senior ...	350 × 15-410	400 × 15-460	13.2	455 × 15-515	12.8	480 × 15-540	5.2
Basic ...	340 × 12½-390 × 10-400	390 × 12½-440 × 10-450	13.5	400 × 15-475	4.2	425 × 15-500	5.7
<i>Almoner</i> Head ...	500 × 25-650	£ 1.4.51 550 × 25-700	8.7	£ 1.5.52 625 × 20-725	8.0	£ 1.12.54 650 × 20-750	3.7
Almoner in sole charge.	380 × 12½-455	430 × 12½-505	12.0	465 × 15-555	9.1	490 × 15-580	4.9
Basic ...	330 × 12½-380	380 × 12½-430	14.0	410 × 15-485	10.5	435 × 15-510	5.5
<i>Radiographer</i> Superintendent	450 × 25-600	£ 1.10.50 475-625	4.8	£ 1.10.51 500 × 25-650	4.5	£ 1.2.54 530 × 25-680	5.2
Single-handed	360 × 25-435	375 × 10-385 × 15-460	5.0	400 × 15-490	6.5	425 × 15-515	5.6
Basic ...	310 × 12½-360	335 × 12½-385	7.5	355 × 15-415	6.9	380 × 15-440	6.5
						£ 5.11.56 675 × 27½-812½ × 37½-850 or 585 × 25-710 × 40-750 470 × 15-545 × 25-570 420 × 15-465 × 20-485	26.0 (Note 6) or 10.3 10.6 10.4

Notes:

1. The term "medical auxiliary" covers some 10 classes of staff sub-divided into 68 grades. For simplicity this schedule is confined to three representative and numerically important classes, each in three representative grades (the lowest, an intermediate and the highest clinical grade). Some of the classes have special grades for those engaged in teaching student medical auxiliaries (Medical Laboratory Technicians who are Medical Auxiliaries as defined in the National Health Service (Medical Auxiliaries) Regulations, 1954, are included on a separate schedule).
2. No information is available about pre-war salaries.
3. The percentage increases shown are calculated on the means of successive scales.
4. Negotiations are taking place on a revision of the current scales for physiotherapists and almoners.
5. The increases in pay in April, 1951 and December, 1954 took account only of changes in economic circumstances. The others also took into account revaluation of duties or followed Arbitration Awards.
6. In November, 1956 two scales were provided for Superintendent Radiographers, the higher being intended only for Superintendents in charge of the largest departments.
7. *Qualifications.* Medical auxiliaries are required to possess recognised professional qualifications given after examination by the appropriate professional body. For the above classes the appropriate bodies are the Chartered Society of Physiotherapists, the Faculty of Physiotherapists and (up to 1954) the Physiotherapists' Association; the Institute of Almoners; the Society of Radiographers.
8. *Hours of duty: overtime.* Normal weekly hours, excluding meal times, are Physiotherapist 36, Almoner 39 and Radiographers 35 (as recommended by the British X-ray and Radium Protection Committee). No payment is made if additional hours are worked but time off in lieu is given as far as possible. Radiographers receive extra payment at an hourly rate for emergency work done outside the working day whilst "standing by" at the hospital or "on-call" at home.
9. *Annual leave.* Physiotherapists and almoners 3-4 weeks according to grade; radiographers 4 weeks.
10. *Charges for meals.* The N.H.S. Whitley Council have not determined charges. Employing authorities base them on the value of the services provided.
11. *Occupational clothing.* Provided and laundered by the employing authority; or a cash allowance is given instead.

APPENDIX V—continued
HOSPITAL PHARMACISTS

SECTION 7

GRADE	5.7.48 (Note 1)		5.7.49 (Note 2)		1.1.52 (Note 4)		1.4.55 (Note 5)		1.1.56 (Note 4)	
	Scale	£	Scale	Per-centage increase	Scale	Per-centage increase	Scale	Per-centage increase	Scale	Per-centage increase
Chief Pharmacist (Note 3) Cat. V	$\left[\begin{array}{l} 1 \text{ Asst. to 5} \\ \text{Assts.} \\ 485-700 \end{array} \right]$	£	—	—	£	—	£	18	£	7
Cat. IV		675 × 25 (6) —825	735 × 25 (6) —885	8	785 × 25 (6) —935	8	835 × 40 (8) —1,155 + 45 (1) —1,200	16	900 × 40 (3)— 1,020 × 45 (5)— 1,245 × 40 (1)— 1,285	7
Cat. III	$\left[\begin{array}{l} \text{Over 5 Assts.} \\ \text{salary at dis-} \\ \text{cretion of} \\ \text{employing} \\ \text{authority} \end{array} \right]$	625 × 25 (4) —725	680 × 25 (4) 780	8	625 × 25 (4) 725	8	730 × 30 (5)— 880 × 40 (3)— 1,000	18	785 × 30 (2)— 845 × 35 (2)— 915 × 40 (3)— 1,035 × 35 (1)— 1,070	7
Cat. II		575 × 25 (4) —675	625 × 25 (4) 725	8	625 × 25 (4) 725	8	675 × 30 (7)— 885 × 40 (1)— 925	19	725 × 30 (2)— 785 × 35 (5)— 960 × 30 (1)— 990	7
Cat. I	420-475 × 15 (5) —495-550	525 × 25 (4) —625	575 × 25 (4) 675	19	575 × 25 (4) 675	9	625 × 30 (7)— 835 × 15 (1)— 850	18	675 × 30 (7)— 885 × 25 (1)— 910	7

Deputy Chief Pharmacist (Note 3) Cat. V	—	—	625 × 25 (4)– 725	—	675 × 30 (7)– 885 × 40 (1)– 925	19	725 × 30 (2)– 785 × 35 (5)– 960 × 30 (1)– 990	7
Cat. IV	425 × 20 (5)– 525 × 15 (1)– 540	525 × 25 (4)– 625	19	575 × 25 (4)– 675	9	625 × 30 (7)– 835 × 15 (1)– 850	675 × 30 (7)– 885 × 25 (1)– 910	7
Senior Pharmacist ...	415 × 15 (5)– 490	475 × 25 (4)– 575	16	525 × 25 (4)– 625	10	575 × 30 (5)– 725 × 25 (2)– 775	650 × 30 (6)– 830	10
Basic Grade Pharmacist	370 × 15 (4)– 430 × 20 (1)– 450	425 × 25 (4)– 525 (Minimum of scale linked to age 23 with abatement of £25 for each year below that age.)	16	450 × 25 (5)– 575 (Minimum of scale linked to age 23 with abatement of £25 for each year below that age.)	8	500 × 25 (3)– 575 × 30 (5)– 725	580 × 30 (6)– 760 × 25 (1)– 785	11

NOTES

1. No information is available about pre-war salaries. The scales in use in July, 1948 were those recommended in October, 1946 by the Joint Negotiating Committee (Hospital Staffs). The Salaries of Chief Pharmacists depended upon the number of their subordinate staff.
2. This was the first N.H.S. Whitley salary and grading structure and was determined on the basis of an Award by the Industrial Court. The duties of the whole class were reviewed and revalued. The new grading structure introduced a grade of Deputy Chief Pharmacist and related the salary of the Chief Pharmacist to the scope and volume of his work instead of the number of subordinate staff.
3. An additional salary scale of Deputy Chief Pharmacist was introduced in 1952 to give higher pay to those with the heaviest responsibilities. For similar reasons an additional scale of Deputy Chief Pharmacist was introduced.
4. The increases given in 1952 and 1956 were intended to take account of changes in economic circumstances. But slightly higher percentage increases were given to the two junior grades to overcome recruitment difficulties.
5. The scales negotiated in 1955 were based not only on changes in economic circumstances but also on a revaluation of duties and responsibilities of the class.
6. Chief Pharmacists in certain teaching hospitals are paid special allowances ranging from £145 to £290 in recognition of extra and special duties arising from association with a medical school.
7. Qualifications. The minimum qualification was the M.P.S. up to 31st December, 1953, but since that date it has been Ph.C. Pharmacists who hold also the qualification of B.Pharm. or A.R.I.C. or F.P.S. or a university degree in a relevant scientific field are paid an extra £25.
8. Hours of duty: overtime, 39 per week (excluding meal times). No payment is made if additional hours are worked, but time off is given instead.
9. Annual leave. Pharmacists receiving less than £1,100 per annum have 18–24 days' leave according to grade. Those receiving £1,100 per annum or more have 36 days' leave.
10. Charges for meals. Under a Whitley agreement on charges for meals employing authorities should base them on the value of the service provided.

APPENDIX V—(continued)
HOSPITAL OPTICIANS

SECTION 8

GRADE	October, 1948	1.1.52	1.12.56	Percentage increase or means of scales
	Scales (Note 3)	Scales (Note 4)	Scales (Note 5)	
Senior Ophthalmic Opticians	£ 900 × 30 (10)–1,200	One within scale increment	£ 930 × 40 (8)–1,250	4
Ophthalmic Opticians with not less than two years' full-time experience since their names were entered on the Central Professional Committee's list.	500 × 25 (12)–800 (Age 24, with abatement of £25 for persons under that age)	Two within scale increments	575 × 30 (10)–875 (Note 2)	12
Ophthalmic Opticians with less than two years' service since their names were entered on the Central Professional Committee's list.	350 (Age 22, with abatement of £25 for persons under that age)	No increase	575 × 30 (10)–875 (Note 2)	64 (Note 6)
Ophthalmic Opticians who have passed their final examination but whose names have not been entered on the Central Professional Committee's list (Note 1).	300 (Age 21 or over, with abatement of £25 for each year or part of a year below age 21)	No increase	385	28
Dispensing Opticians	300 × 25 (12)–600	Two within scale increments	450 × 25 (2)–500 × 30 (8) –740 × 10 (1)–750	33

NOTES:

1. Ophthalmic and Dispensing Opticians must have some post-graduate experience before their names are entered on the lists of the Central Professional Committee.
2. From 1st December, 1956, the "two years" experience and the "under age" abatement requirements were abolished and this scale applies to all ophthalmic opticians whose names are entered on the list of the Central Professional Committee.
3. This was the first national scale and was agreed after negotiations with the optical professions. Opticians were not employed in hospitals until 1948.

4. An interim award was made to opticians in post of one or two increments as shown or an amount required to reach the maximum of the scale, whichever was the less, pending further consideration of relatives with opticians employed outside the hospital eye service.
5. This scale was based not only on changes in economic circumstances but also on a revaluation of the duties and responsibilities of the class; hospital recruitment difficulties, particularly in the case of dispensing opticians, were a predominant factor.
6. Calculated at minimum of new scale (£575).
7. *Part-time* ophthalmic opticians and dispensing opticians have, since 1948, been paid £3 3s. 0d. and £2 2s. 0d. respectively for each session (normally 3 hours).
8. *Supervisory Allowance for Dispensing Opticians.* £50 p.a. is payable to dispensing opticians with supervisory responsibilities, in departments with two or more dispensing opticians.
9. *Special work allowance for Senior Ophthalmic, Ophthalmic and Dispensing Opticians.* £75 p.a. is payable to opticians substantially engaged on work requiring special skill and additional training and qualifications, e.g. contact lens work.
10. *Additional Payment to Senior Ophthalmic Opticians.* Where the duties performed by a Senior Ophthalmic Optician are above those appropriate to his grade, the Optical Whitley Council investigates the matter with a view to additional payment.
11. *Qualifications.* *Ophthalmic Opticians* are required to have one of the following qualifications:—
 - Fellowship Diploma of the British Optical Association.
 - Fellowship Diploma of the Worshipful Company of Spectacle Makers.
 - Fellowship Diploma of the National Association of Opticians.
 - Fellowship Diploma of the Scottish Association of Opticians.
 - Ordinary Membership Certificate of the Institute of Optical Science.*Dispensing Opticians* are required to have one of certain specified qualifications which include the dispensing certificate of the recognised examining bodies for Ophthalmic Opticians, or the Fellowship Diploma of the Association of Dispensing Opticians, or to have passed the practical side of the final dispensing examination of the Association of Dispensing Opticians and have been engaged as a dispensing optician for a period of five years.
12. *Hours of work.* 39 per week (excluding meal-times).
13. *Annual leave.* On salaries below £1,100: 3-4 weeks according to grade and salary. On salaries above £1,100: 6 weeks.

APPENDIX V—(continued)
BIOCHEMISTS AND PHYSICISTS

SECTION 9

GRADE	1st January, 1951 (Note 1)	1st January, 1953		1st April, 1955	
	£	Scale £	Per cent increase	Scale £	Per cent increase
Basic ...	375 × 25–475 550 × 30–730	410 × 25–510 585 × 30–765 (Note 2)	6·3	475 × 25–575 650 × 30–740* 35–845 (Note 2)	12·3
Senior ...	800 × 40–1,080	835 × 40–1,035 × 25–1,060 × 20–1,080	1·9	910 × 40–1,230	11·7
Principal ...	1,125 × 50–1,375	1,125 × 50–1,375	Nil	1,280 × 50–1,530	12·4
Top ...	1,425 × 75–1,725 (Note 4)	1,425 × 75–1,725 (Note 4)	Nil	1,600 × 75–1,900 (Note 4)	11·1

Notes:

1. No information is available about salaries paid before the war. Little information is available about salaries before 1951. In 1950 information was collected which suggested that about 9 out of 10 biochemists and physicists earned less than £1,000, the average being about £700.
2. New entrants may be appointed above the minimum of the basic scale if they have had appropriate post-graduate study or experience.
3. The increases given in 1953 took account only of changes in economic circumstances but those in 1955 were based also on a review of the duties and responsibilities of the class. The percentage increases shown are calculated on the means of successive scales.
4. These are minimum scales. A higher scale can be paid for a particular top grade post if, in the opinion of the Minister or Secretary of State, the duties of that post justify it.
5. *Hours of duty.* Such as are necessary for the proper and efficient performance of the work.
6. *Annual leave.* 3–4 weeks according to grade, on salaries less than £1,100, 6 weeks on salaries of £1,100 or more.
7. *Qualifications.* Biochemists and Physicists must be science graduates of British Universities or, for Biochemists only, Associates of the Royal Institute of Chemistry.

Royal Commission on
Doctors' and Dentists' Remuneration

WRITTEN EVIDENCE
VOLUME 2

*Memoranda of Evidence
of Selected Representative
Organisations*

LONDON
HER MAJESTY'S STATIONERY OFFICE
1960

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ROYAL COMMISSION
ON DOCTORS' AND DENTISTS'
REMUNERATION

INDEX TO
ORAL AND WRITTEN
EVIDENCE



LONDON:
HER MAJESTY'S STATIONERY OFFICE
1961

THREE SHILLINGS NET

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INTRODUCTION

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- (i) the Minutes of oral evidence published in daily parts, incorporating the written memoranda previously submitted by the witnesses who attended;
- (ii) supplementary written memoranda submitted by some witnesses following oral hearings and published in the Appendix to the Minutes of Evidence;
- (iii) a factual memorandum prepared by the Ministry of Health and the Department of Health for Scotland and published as "Written Evidence—Volume 1";
- (iv) certain written memoranda of selected representative organisations who were not asked to give oral evidence, published as "Written Evidence—Volume 2".

THE ROYAL COMMISSION'S PUBLICATIONS OF ORAL AND WRITTEN EVIDENCE

Minutes of Evidence Day

1(1)	Socialist Medical Association	Dr. D. Stark Murray Dr. H. Joules Dr. D. Kerr
1(2)	Whole-Time Consultants' Association ..	Dr. C. Allan Birch Dr. A. A. Cunningham Dr. L. T. Hilliard Dr. R. M. Mayon-White
2	Joint Consultants' Committee (also 21st Day)	Sir Russell Brain Mr. T. Holmes Sellors Dr. J. D. S. Cameron Dr. T. Rowland Hill
3	Medical Practitioners' Union	Dr. B. Cardew Dr. A. Elliott Dr. H. C. Faulkner Dr. P. Hopkins Dr. H. Walden
4	The Lord Moran of Manton	
5/6	British Medical Association (also 23rd Day)	Dr. S. Wand Dr. A. B. Davies Mr. T. Holmes Sellors Dr. A. Macrae Dr. D. P. Stevenson Professor R. G. D. Allen Mr. S. B. R. Cooke Mr. N. Leigh Taylor *Dr. L. S. Potter
	* 6th day only.	
7	Royal College of Physicians of London ..	Dr. Robert Platt Sir Russell Brain Sir Harold Boldero
8	General Dental Practitioners Association	Dr. K. Malik Mr. F. Barlow Mr. R. C. Brennan Mr. D. Daker Mrs. J. D. Thorburn Mr. B. Deakin Mr. I. Harder
9	General Practice Reform Association ..	Dr. A. C. J. Saudeck Dr. H. P. Hilditch Dr. L. Russell Dr. J. J. Segall
10	Royal Faculty of Physicians and Surgeons of Glasgow	Professor S. Alstead Dr. J. H. Wright Mr. R. B. Wright
11(1)	Royal College of Surgeons of Edinburgh ..	Professor J. Bruce Professor N. M. Dott Mr. J. J. Mason Brown
11(2)	Royal College of Physicians of Edinburgh	Dr. A. Rae Gilchrist Dr. J. K. Slater Dr. W. I. Card

Day					
12/13	British Dental Association	..	..	..	Mr. L. E. Balding Mr. R. G. Swiss Mr. C. W. F. Thomas Mr. J. P. Cocker Mr. T. Hindle Mr. H. Parker Buchanan Mr. H. D. Barry Mr. G. W. Marshall Professor R. G. D. Allen Mr. R. C. Simmonds Mr. H. J. Fricker
14/15	H.M. Treasury	..	..	..	Sir Thomas Padmore Mr. A. J. D. Winniffrith
	Ministry of Health	..	..	..	Sir John Hawton Dame Enid Russell-Smith Mr. D. A. V. Allen
	Department of Health for Scotland	..			Mr. J. Anderson Mr. N. W. Graham
	Central Statistical Office	..	..	..	Mr. J. L. Nicholson
16	Royal College of Surgeons of England	..			Sir James Puterson Ross Sir Harry Platt Mr. H. Edwards Sir Wilfred Fish Sir William Kelsey Fry Professor R. V. Bradlaw
17	Royal College of Obstetricians and Gynaecologists				Professor A. M. Claye Mr. T. L. T. Lewis Mr. H. J. Malkin Mr. J. H. Peel
18(1)	Society of Medical Officers of Health	..			Dr. H. D. Chalke Dr. E. Hughes Dr. J. B. Tilley Sir Selwyn Selwyn-Clarke Dr. I. C. Monro
	Society of Medical Officers of Health (Scottish Branch)				
18(2)	Association of County Medical Officers of Health of England and Wales				Dr. A. Elliott Dr. J. S. Cookson Dr. C. D. L. Lycett Dr. G. Ramage
19(1)	Medical Research Council	..	..	..	Sir Harold Himsworth
19(2)	Committee of Vice-Chancellors and Principals of the Universities of the United Kingdom				Sir Philip Morris Dr. R. S. Aitken Mr. J. S. Fulton Dr. T. M. Knox Dr. D. W. Logan Sir Folliott Sandford
20(1)	Scottish Association of Medical Administrators				Dr. S. G. M. Francis Dr. C. Bainbridge Dr. F. D. Beddard Dr. W. Muckle Dr. P. W. Petrie
20(2)	Medical Superintendents' Society	..	..	..	Dr. G. McCoull Dr. M. J. Brookes Dr. V. Cotton-Cornwall Dr. A. Skene Mr. J. M. Milloy

Day		
21	Joint Consultants' Committee (also 2nd Day)	Mr. T. Holmes Sellors Sir Harold Boldero Dr. J. D. S. Cameron Dr. T. Rowland Hill Mr. J. P. Cocker Dr. D. P. Stevenson
22(1)	Scottish Medical Practices Committee ..	Dr. J. T. Baldwin Mr. A. I. Millar Mr. J. McCallum Mr. A. B. Fairweather
22(2)	Scottish Association of Executive Councils	Dr. J. M. Gill Colonel R. S. Weir Mr. T. Hunter Mr. A. R. Howie
23	British Medical Association (also 5th and 6th Days)	Dr. S. Wand Mr. H. H. Langston Mr. J. R. Nicholson-Lailey Dr. G. Waring Robinson Dr. T. L. Reeves Mr. R. Brearley Dr. H. Watson Dr. I. Rannie Mr. O. Gayer Morgan Dr. A. B. Davies Dr. J. B. Tilley Dr. H. D. Chalke Mr. S. B. R. Cooke Dr. D. P. Stevenson

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Notes.—1. The following abbreviations are used in order to identify the Royal Commission's publications in which the references are to be found:

- Figures in bold print, e.g. **12/13** .. Minutes of Evidence.
App. Appendix to Minutes of Evidence.
Vol. 1 Written Evidence, Volume 1
 (Factual Memorandum).
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2. All references in the Index to members of the medical and dental professions, unless otherwise indicated, are to those doctors and dentists who are practising in the National Health Service.

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1. The value of self-liquidating before the opening of the Village Youth Center.
2. The value of self-liquidating after the opening of the Village Youth Center.
3. Value the benefits of Village Youth Center on the Village Youth Center and Village Youth Center according to the weighted importance.
4. Use an algebraic method to solve the problem of the Village Youth Center.
5. Add the value of the Village Youth Center to the value of the Village Youth Center. The percentage of the value of the Village Youth Center is the value of the Village Youth Center.
6. The value of the Village Youth Center is the value of the Village Youth Center.
7. The value of the Village Youth Center is the value of the Village Youth Center.
8. The value of the Village Youth Center is the value of the Village Youth Center.
9. The value of the Village Youth Center is the value of the Village Youth Center.
10. The value of the Village Youth Center is the value of the Village Youth Center.

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Category	Period	Metric	Value	Unit	Trend	Detailed Analysis and Strategic Insights									
						Sub-category	Sub-category	Sub-category	Sub-category	Sub-category	Sub-category	Sub-category	Sub-category	Sub-category	Sub-category
Category A	Q1-2023	100	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000
	Q2-2023	100	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000	100.000
Category B	Q1-2023	200	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000
	Q2-2023	200	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000	200.000
Category C	Q1-2023	300	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000
	Q2-2023	300	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000	300.000
Category D	Q1-2023	400	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000
	Q2-2023	400	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000	400.000
Category E	Q1-2023	500	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000
	Q2-2023	500	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000	500.000
Category F	Q1-2023	600	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000
	Q2-2023	600	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000	600.000
Category G	Q1-2023	700	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000
	Q2-2023	700	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000	700.000
Category H	Q1-2023	800	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000
	Q2-2023	800	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000	800.000
Category I	Q1-2023	900	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000
	Q2-2023	900	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000	900.000
Category J	Q1-2023	1000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000
	Q2-2023	1000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000	1000.000

SPECIAL LAMINATED WORKSHEETS

Grade	1.1st (Year 1)		1.2nd (Year 2)		1.3rd (Year 3)		2.1st (Year 4)		2.2nd (Year 5)		2.3rd (Year 6)	
	Grade	No. of pages	Grade	No. of pages	Grade	No. of pages	Grade	No. of pages	Grade	No. of pages	Grade	No. of pages
Class 1 (Year 1)	1	—	1	—	1	—	1	—	1	—	1	—
Class 2 (Year 2)	2	—	2	—	2	—	2	—	2	—	2	—
Class 3 (Year 3)	3	—	3	—	3	—	3	—	3	—	3	—
Class 4 (Year 4)	4	—	4	—	4	—	4	—	4	—	4	—
Class 5 (Year 5)	5	—	5	—	5	—	5	—	5	—	5	—
Class 6 (Year 6)	6	—	6	—	6	—	6	—	6	—	6	—

Notes

- The University's website (www.universityofsouthampton.ac.uk) contains information about the University's policies and procedures.
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